STATE TITLE V BLOCK GRANT NARRATIVE
STATE: MD
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The required assurances and certifications have been signed by Secretary McCann and housed in the Center for Maternal and Child Health's central offices. The assurances and certifications can be made available to the Maternal and Child Health Bureau upon request.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

A notice was placed in the Maryland Register inviting the public to review and comment on the 2006 application and needs assessment. There were no comments received in response to the Maryland Register notice. However, over 1,000 MCH stakeholders including parents, health providers, local health department MCH directors, and others were involved in formulating the needs assessment for the 2006 application. Upon final approval of the application and state performance measures by MCHB, the Maryland Title V Program plans to hold regional meetings throughout the state to highlight needs assessment findings and to gather community support for strategies that will improve the health of Maryland's MCH population. Comments and additional recommendations gathered through these meetings will be considered and incorporated into MCH planning over the next four years. Links to both the needs assessment and the 2006 application will be accessible from several Family Health Administration Webpages.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

According to the U.S. Census, Maryland was home to 5,558,058 residents in 2004. This included 374,578 young children under the age of five; 368,612 elementary school aged children between the ages of five to nine; 806,368 adolescents between the ages of ten to nineteen; and 366,452 young adults ages 20-24. Maryland is comprised of 23 counties and the City of Baltimore and is characterized by mountainous rural area in the Western part of the State, densely populated urban and suburban areas in the central and southern regions and flat rural areas on the Eastern Shore. The State borders West Virginia, Pennsylvania, Washington, D. C., Delaware and the Atlantic Ocean. Maryland has 9,837 square miles of land area, 623 square miles of inland waters and 1,726 square miles that constitute the Chesapeake Bay, the world's largest estuary. In 2004, Maryland ranked 19th in population and 6th in population density among states (including the District of Columbia) with 541.9 persons per square land mile.

Maryland's population grew by 4.9% as compared to an overall U.S. growth rate of 4.3% between 2000 and 2004. Montgomery and Prince George's counties, both part of the Washington D.C. suburbs, accounted for the majority of this population growth. Conversely, the population of Baltimore City continued to decline, decreasing by 14% during this same time period. The majority of Maryland residents (75%) live in the major metropolitan areas that surround either Baltimore City or Washington D.C., while 11% live in Baltimore City and 14% in the rural areas of Western and Southern Maryland and on the Eastern Shore. The Baltimore-Washington D.C. combined Metropolitan Statistical Area constitutes the nation's fourth largest retail market. Approximately 11% of the state lives in the urban area of Baltimore City, 14% in the rural areas in Western Maryland, on the Eastern Shore and in Southern, and the remaining

The state's 1,549,558 children and adolescents ages 0-19 represented 27.8% of Maryland's population in 2004. Senior citizens, aged 65 and over, represented 11.4% of the population. The median age was 36.9 years. An estimated 1.2 million women of childbearing age (ages 15-45) lived in Maryland in 2004. Between 1999 and 2003, an average of 73,463 babies were born each year. The state's birth rate has been declining overall as well as for most racial and ethnic groups.

With the exception of Western Maryland, the State's minority racial and ethnic populations are rapidly increasing and comprise a significant portion of the population of each geographic area. Racially, Maryland's population was distributed as follows in 2003: 65.6% were Caucasian, 28% were African American, 4.4% were Asian, 1.4% were Two or More Races and les than one percent were American Indian or Native Hawaiian. As a whole, racial minorities comprised an estimated 34.3% of Maryland's population in 2003, up from 28% in 1990. Of the 1.9 million racial minority residents in Maryland, African Americans represented 82% in 2003. Hispanics, the fasting growing ethnic minority in Maryland, represented 4.7% of the total State population in 2003. Compared to the national average, Maryland has a greater proportion of African-Americans (two times the average) and a lower percentage of Hispanics (one third of the average).

Maryland's undocumented immigrant population has continued to increase. Between 2000 and 2004, the numbers of undocumented immigrants in Maryland are estimated to have doubled from 120,000 to approximately 250,000 (Pew Hispanic Center, Estimates of the Size and Characteristics of the Undocumented Population). A large percent of undocumented residents are women, and about one in six are children. While nationally, 57% of this population migrates from Mexico, Maryland's Hispanic immigrants are predominantly from Central America and the Caribbean islands. The increasing numbers of undocumented women and children, coupled with state budgetary constraints, has strained the ability of local health departments to provide and maintain services for uninsured MCH populations.

U.S. Census data for Maryland indicate that both the total number of poor persons and the poverty rate rose between 1990 and 2000. The Census reported that 438,700 Marylanders (8.3% of the total population) lived in poverty in 1999, however Maryland's poverty rate for 2003 was 10.4%. Still,

Maryland hosts some of the wealthiest communities and jurisdictions in the nation. Maryland continues to be one of the wealthiest states in the nation with per capita, median and mean household incomes that consistently rank within the top five nationally. Maryland ranked as the nation's second richest state with a median household income of $57,218 in 2003 according to the Census Bureau's American Community Survey.

Nationally, Maryland's poverty rate placed it at the third lowest in the nation. Poverty rates vary by race/ethnicity and jurisdiction in Maryland. For example, the poverty rate for African Americans is two to three times higher than the rate for Caucasian Americans. The 2003 Governor's Commission on Poverty noted that the state has several "areas of concentrated poverty" particularly in Baltimore City, in Western Maryland and on the Eastern Shore. These areas are characterized by high unemployment, high crime and violence, teen parenting, a lack of father figures, low performing schools and deteriorating and physical environments. Children living in these communities are increased risk for a host of poor health outcomes.

While the majority of regions in Maryland experienced an economic boom during the 1990's, the Eastern Shore and Western Maryland experienced a decrease in their economic prosperity that has continued in the new millennium. By jurisdiction, the poverty rate for individuals ranged from a low of 3.8% in Carroll County to a high of 22.9% in Baltimore City in 1999. The poverty rate for children under the age of 18 stood at 10.3% statewide in 1999 and ranged from a high of 30.6% in Baltimore City to a low of 3.8% in Howard County.

Among all states, Maryland's workforce is one of the best educated. Over a third of Maryland's population aged 25 and older held a bachelor's degree or higher in 2003. More than 146,455 businesses employ 2.29 million workers. Seventy two percent of people employed were private wage and salary workers; 23% were Federal, state or local government workers; and 5 percent were self-employed in 2003. Health care represents a $26.5 billion industry in Maryland with per capita spending on health care reaching $4,811 in 2003.

In spite of Maryland's affluence and many positive attributes, health indicators for the State remain mixed. In the latest Annie E. Casey Foundation ranking of states on child well-being, Maryland ranked 27th on 10 indicators of child well-being. On the positive side, as the state's lowest needs assessment report shows, fewer women are smoking during pregnancy and more are initiating breastfeeding in the early postpartum period. Teen birth as well as child and adolescent death rates continue to decline. More children are being screened for lead exposure and fewer are being found with elevated blood lead levels. There are fewer uninsured children and more young children are being fully immunized. Fewer adolescents are smoking and juvenile arrests for violent crimes are down.

One area of continuing concern is the state's infant mortality rate. Maryland's infant mortality rate at 8.1 infant deaths per 1,000 live births in 2003 remains one of the highest in the nation. The state's infant mortality rate increased by 7% between 2002 and 2003 and current projections are that the rate has risen even higher in 2004. The Title V Program is currently conducting a review of infant deaths in the state and will report the findings in next year's application. Significant racial disparities remain in state with African Americans continuing to have significantly poorer perinatal outcomes than mothers and babies in other racial and ethnic groups. Maryland has identified the elimination of health disparities as a priority.

Another area of concern is the growing number of uninsured Marylanders, particularly the adult population. Over 740,000 Marylanders lacked health insurance coverage in 2002-2003. An estimated 140,000 of the state's uninsured were children between the ages of 0-18. Between 2001-2002 and 2002-2003, the state's uninsured non-elderly population increased by 60,000 while the numbers of uninsured children declined by 10,000. The state's MCHP program which provided insurance coverage to 150,643 children at some point during FY 2004 is partially credited with the decline in uninsured children. Black (13%), Hispanic (24%) and Asian (15%) children were three to six times more likely than White children (4%) to be uninsured.

The non-elderly uninsured rate was 15.3%, approximately two percentage points below the national average of 17.4% in 2002-2003. Fewer Maryland employers are offering insurance coverage as a benefit. The state's employment based coverage rate is estimated to have declined from 77 to 75 percent during 2000-2002 and continued falling to 72 percent in 2002-2003. Uninsured rates for non-elderly adults varied by race/ethnicity and were lowest for Whites (10%), followed by Blacks (17%), Asians (22%) and Hispanics (48%). Hispanics comprised 23% of the state's uninsured, but only 7% of the state's non-elderly population. Uninsured rates varied by poverty level and were highest for persons in families with incomes below the poverty level (39%). Only half of poor persons were enrolled in Medicaid.

Injuries remain as the leading cause of child and adolescent deaths. Two major environmentally linked health conditions - asthma and lead poisoning -- continue as major causes of childhood morbidity. An estimated 153,000 Maryland children and adolescents have asthma. In 2003, 3,349 children were diagnosed with elevated blood lead levels (defined as a venous or capillary blood lead level >= 10 ug/dL). Obesity and obesity related illnesses such as type 2 diabetes are documented to be increasing among children and adolescents. The 2005 needs assessment reports that health providers and school health personnel are increasingly identifying depression and mental health disorders as problems among adolescents.

Twenty of Maryland's 24 jurisdictions are currently either entirely or partially federally designated as medically underserved areas for primary care services. This occurs even though the ratio of primary care physicians to the population is higher in Maryland than the national average. Part of this higher representation is based on the high number of physicians employed by government research facilities, military and medical schools, in non-direct health care positions. Four of Maryland's twenty-four jurisdictions are currently classified as being underserved for dental health services/manpower and six jurisdictions are classified as underserved for mental health services. There are federally qualified community health centers in 17 jurisdictions.

The Medicaid Program, known in Maryland as the Medical Assistance Program, serves as the major source of publicly sponsored health insurance coverage for children and adolescents. The Maryland Children's Health Program (MCHP) began operating as a Medicaid expansion program on July 1, 1998. The MCHP program expanded coverage for comprehensive health insurance for children up to the age of 19 with family incomes at or below 200 percent of the Federal Poverty Level (FLP). In 2001 Maryland initiated a separate children's health insurance program expansion, MCHP Premium. In FY 2004, 397,060 children and adolescents were enrolled in the Medicaid Program at some point during the year, while 150,643 were enrolled in MCHP. MCHP also provides insurance coverage for pregnant women with incomes between 185% and 250% of the federal poverty level. In FY 2004, Medicaid covered hospital delivery costs for approximately one-third of Maryland births.

More detailed MCH-related health status indicators are reported on in the Needs Assessment Section and/or the Health Status Indicator Section. Other emerging health trends, problems, gaps and barriers are also identified in the 2005 Needs Assessment Report.

State Health Agency Priorities

The mission of the Maryland Department of Health and Mental Hygiene is to protect and promote the health of the public by creating healthy people in healthy communities; to strengthen partnerships between state and local governments, the business community and all health care providers in Maryland; and to build a world class organization grounded in the principles of quality and learning, accountability, cultural sensitivity and efficiency.

Mr. S. Anthony McCann and Dr. Michelle Gourdine were appointed Secretary and Deputy Secretary for Public Health Services, respectively in FY 2005. Secretary McCann has stated that improving quality within the health care system is his priority for the next 6 years. Dr. Gourdine, the former Baltimore County Health Officer, has indicated that two of her top priorities are succession planning

(developing the next generation of public health leaders) and public health prevention.

The elimination of health disparities remains as a DHMH priority. Objectives to address health disparities within the State's Health Improvement Plan for 2010. The Maryland General Assembly passed legislation in 2003 requiring the DHMH to develop and implement a plan to reduce health care disparities based on race/ethnicity, gender and poverty. The 2004 Maryland General Assembly passed legislation calling for the establishment of an Office of Health Disparities and Minority Health in the Department of Health and Mental Hygiene. This Office which is headed by Dr. Carleissa Hussein, sponsored the sponsored two statewide conferences on health disparities and is currently finalizing a state's health disparities plan.

For the past three years, Department of Health and Mental Hygiene, the Family Health Administration and the Maternal and Child Health Offices have dealt continuously with budget, personnel and resource reductions. The state's public health system has faced severe budget reductions and other federal and state priorities, including Medicaid and emergency preparedness expenditures. Recently, programs within DHMH have been permitted to request and are receiving freeze exemptions for recent vacancies that have occurred because of employees' retirement. While improvement in hiring is beginning to occur, past fiscal decisions have slowed the Department's ability to sustain and develop public health programs. It is anticipated that progress will be made but at a very slow rate.

The Family Health Administration's priorities will continue to focus on strengthening programs, as well as revitalizing public health data; building public health partnerships (with the academic centers, professional and advocacy groups, and others); and strengthening operational aspects of public health administration (e.g., budget, personnel, procurement, legislation, information technology). In addition, a major FHA focus will be on leadership development with special attention on developing and mentoring the next generation of public health leaders.

MCH/CSHCN Program Priorities

The Center for Maternal and Child Health Program priorities for the next four years include the following:

Assuring access to family planning services continues as a priority. This includes assuring that the program maximizes resources, and minimizes costs while continuing to offer convenient no-cost/low-cost services through a diverse network of providers, to reach more women in need. This is to be done without sacrificing the current level of comprehensiveness or quality of services. Family planning services is one of the strategies for reducing infant mortality because women will be healthier and pregnancy will occur within a planned period to time.

Improving key indicators for the health of women and children (i.e., decreasing unintended pregnancy and fetal and infant mortality; and sustaining and increasing progress in teen pregnancy prevention). Reducing maternal, infant and child mortality and improving health outcomes will be achieved through the implementation of maternal mortality, fetal and infant mortality and child fatality review processes; the implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS); and the continuation of local health department based home visiting and care coordination programs.

The state has developed a plan to eliminate elevated blood lead levels in children by 2010. CMCH will continue to work on activities to promote blood lead screening and collaborating with other agencies to reduce elevated blood lead levels in children under age 6.

Another priority focus will be on advancing new prevention priorities in the areas of environmental health (i.e., asthma) and healthy nutrition/physical activity to address obesity and overweight across the life span. CMCH is the recipient of a CDC asthma intervention grant and also is responsible for administering the legislatively mandated Asthma Control Program.

CMCH is also administering a MCHB funded early childhood grant. The Program will focus on developing a comprehensive approach to early childhood health that is fully integrated with broader, more comprehensive efforts aimed at healthy child development. The same approach will be used to develop a plan for improving adolescent health.

During the coming year, CMCH will also focus on refining the five year MCH strategic plan with input from local health departments, health providers, family groups, community based organizations, advocacy groups and other MCH stakeholders. This will be done in conjunction with the Office for Genetics and Children with Special Health Care Needs. Finally, enhance the data and epidemiological capacity of the MCH Program is a continuing priority.

The Office for Genetics and Children with Special Health Care Needs will be dealing with a number of significant issues in the next few years. In general, the structural State budget deficit and resulting cuts to the Departmental budget and an increasingly conservative political climate create challenges for all public health programs, including MCH programs. More specifically, on the genetics front, these include the fragmentation of the newborn bloodspot screening program by the licensure of a private laboratory in competition with the State Public Health Laboratory, obtaining the legislative changes needed to bring the birth defects program up to the new CDC standards, and the closure of the AFP/Quadruple Marker Screening laboratory in the State Public Health Laboratory.

On the CSHCN front, the issues include the creation of a cabinet level Office of Disabilities, major changes to the REM (Rare and Expensive Disease Case Management) Program in Medicaid, the transition of the CMS (Children's Medical Services) program to electronic bill paying, the elimination of Medicaid coverage for legal immigrants, new legislation mandating a pilot autism screening project and overcoming barriers to collaborating with partners outside State government such as professional organizations, like the Maryland Chapter of the AAP.

In 2000, NeoGen Screening, a commercial newborn screening laboratory, appealed the denial of a license to conduct newborn screening in Maryland. NeoGen had previously been granted a license as a molecular diagnostic laboratory, but had been denied a license to do newborn screening. In May of 2002 NeoGen Screening received a license to perform newborn screening tests as part of a settlement agreement. Under the terms of the settlement, Neo Gen was to report abnormal test results to the Newborn Screening Follow-Up unit in the OGCSHCN who would continue to provide follow up services. NeoGen was also to provide data on all Maryland babies screened to the Follow -- Up unit and to provide data on the babies it screened for required reports, such as the MCH Block Grant and the National Newborn Screening and Genetics Resource Center' s annual report. NeoGen Screening was then acquired by Pediatrix. The new leadership was much less experienced with newborn screening and the mechanics of comprehensive state newborn screening programs.

Despite the best efforts of all concerned, the difficulties of running a comprehensive State newborn screening program with two laboratories have proven much greater than anticipated. Meshing the 2 data systems has been much more difficult than expected. This has been further complicated by individuals interpretation of HIPAA compliance requirements and the expectations of all parties. Consequently, Maryland's newborn screening data may be incomplete. Maryland continues to address these issues and anticipates as the "learning curve" evolves a significant number of these concerns will be resolved. This affects both blood spot screening and hearing screening because Maryland collects the results of hearing screening performed in the hospital before discharge on the newborn blood spot screening lab slip. This issue is will increase in significance as more Maryland hospitals use Pediatrix.

In CY 2004, Pediatrix screened about 5% of the babies. By the beginning of 2005, Pediatrix had contracts in place to cover approximately one third of babies born in Maryland. (Maryland has a routine 2 specimen system and some babies, for instance premies or babies with mildly abnormal results, may have more specimens.) Work on database issues and negotiations on reporting are ongoing.

The Maryland Birth Defects Reporting and Information System (BDRIS) currently receives a grade of C from the Trust for America's Health. While praising the timeliness of Maryland data, Maryland's use of the data it collects, and the information and referral services it provides, the Maryland system is marked down because it does not collect data on all birth defects and because it does not have clear-cut authority to access medical records. These deficiencies will have to be corrected for the Maryland system to meet the newly published CDC standards.

A bill was introduced in the 2005 legislative session to correct these deficiencies. It was amended in the House of Delegates because the parents of children with facial clefts felt that it was discriminatory to allow hospitals to release information about babies with birth defects to the Department without the informed consent of their parents while asking for informed consent to release information about possible control babies to the Department, so that the program could invite possible controls to participate in case/ control studies. (Informed consent is always obtained before including babies with or without birth defects in studies that are purely research and not investigations necessary to protect the public health.) The amended bill allowed the hospitals to provide initial information, contact information only in the case of control babies, without informed consent. This was felt by the parents to treat cases and controls the same way. The bill passed the House but failed in the Senate because some Senators thought it was unacceptable for even contact information on infants without birth defects to be released to the Department without explicit informed consent, even though the information would only be used to contact the families to get informed consent. This impasse will have to be resolved if the Maryland system is to be brought up to national standards.

In the early 1980s the State Public Health Laboratory began to provide maternal serum AFP testing. When AFP testing began to be available in the private sector, the State decided not to establish AFP testing as a State program for all pregnant women. The State left the provision of this test to the private sector and only provided it as a service to low income women who could otherwise not access the test. The number of women utilizing this service declined dramatically after 1997 when medical assistance patients were transitioned to MCOs. The State AFP/ Quadruple Marker Laboratory was closed in February 2004 since approximately 3000 women were tested. A short term contract to serve this patient population was established with the genetics laboratory at the University of Maryland. OGCSHCN continues to assess ways to continue funding this genetic test new that the interim funds have been depleted. None of these low income women are eligible for any public insurance program.

The Department of Disability was elevated to cabinet level in 2004. The Department of Disability was charged with writing a Statewide disability plan. All State programs providing services to persons with disabilities were required to report their activities to the new Department of Disability every year and to configure their programs to achieve the plans goals. The plan has just been released. The Department of Disability is granted very broad authority to implement the plan. It is not yet clear what the impact on the programs of the OGCSHCN will be. The programs of the OGCSHCN serve some children with disabilities and some who are not considered disabled.

The future of the REM program has been a prominent issue this year and will continue to be a highly visible issue in the next year. The REM (Rare and Expensive Disease Case Management) Program was created in 1997 at the time that Medicaid transitioned its patients into managed care (HealthChoice). Only a few special populations remained in fee for service Medicaid. Among these were a small number of patients with rare, expensive, complex disorders who were judged very likely to do poorly in the managed care setting. A major concern was that the MCOs had not yet developed adequate networks of specialty providers, especially pediatric specialty providers. The REM patients receive case management and remain in fee for service Medicaid. They are allowed to assemble their own group of specialists, free of network constraints, and to have access to services not ordinarily covered by Medicaid if these are required for their care.

The REM population contained many CSHCN; 2850 (85%) of the approximately 3,300 patients enrolled in the program were CSHCN. Since diagnosis was the major criterion for eligibility for REM, there was a broad spectrum of severity for each diagnosis. Fewer than 6% of the REM patients accounted for over 40% of total REM expenditures. Approximately 20% of the highest cost patients

are in their terminal year of life. Due to the total cost of the TEM case management and its impact on the total Medicaid budget, in 2004, case management was eliminated for approximately two thirds of REM patients and retained only for the most severely affected third.

Various committee reports found that, with more developed specialty provider networks and improved case management, MCOs were now successfully handling many patients as complex as REM patients whose diagnoses were too common for eligibility in REM. The elimination of REM and transition of REM patients into HealthChoice MCOs was proposed as an additional cost containment measure. However, budget language in the FY 2006 budget retains the program for another year but requires a number of reports including a study of the utilization of durable medical equipment, the development of cost containment strategies and the consideration of alternatives to the program. Changes to REM or the elimination of REM may have a substantial impact on the CSHCN program. The CMS program has historically provided "underinsured" low income CSHCN with specialty care services that are not covered by Medicaid or private insurers. Many benefit packages in the private sector do not cover care or services needed by CSHCN with complex problems. In 2004, 56% of the calls received by Parent's Place of Maryland (funded by OGCSHCN) are from families with private insurance whose insurance does not cover items needed by their children.

To comply with HIPAA, the CMS program is working on a system to pay bills electronically and proving to be more difficult than anticipated.

The FY2006 State budget eliminates Medicaid eligibility for approximately 3,000 children who are legal immigrants but who have not lived in Maryland for a minimum of 5 years. It is anticipated that some of the children with special health care needs in that group will seek fee for service coverage for their specialty care from the CMS program. This could potentially increase the caseload in the CMS program by 450 children, which is approximately 3 times the number of patients currently in the program.

Autism will also be a prominent issue in the near future. A bill to establish a pilot program of screening for the early identification of autism was passed in the 2005 legislative session. The project is based in the Maryland Department of Education but the Department of Health and Mental Hygiene is collaborating and the Associate Director of the OGCSHCN, who is a developmental pediatrician, serves on the advisory board for the project. In addition, the Director of the OGCSHCN serves on the Advisory board of the Center for Autism and Developmental Disabilities Epidemiology based at the Johns Hopkins School of Public Health.

OGCSHCN staff will work to overcome the barriers to collaborating with partners outside State government on an increasing number of grants that require such collaboration. Both the Champions for Progress Grant and the Medical Home Work Group require collaboration with the Maryland Chapter of the American Academy of Pediatrics. The State procurement system makes it almost impossible for a State agency to provide such a professional organization with the funding for its part of the grant. In addition, the Maryland AAP Chapter lacks the staff and organization to do its part. This is an increasing concern since many new initiatives require such collaboration.

B. AGENCY CAPACITY

B. Agency Capacity

Both the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHN), hereafter referred to as the MCH Program, share responsibility for MCH Block Grant development and implementation. The mission of the Maryland's MCH Program is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health

disparities, and strengthening the MCH infrastructure.

The MCH Program is responsible for addressing several federal (e.g., Title V and Title X) and state mandates for improving the health of women and children. State statutes relevant to Title V program authority include the following:

Child Fatality Review Teams (HEALTH GENERAL, Article 5, SS701) -- Establishes multi-disciplinary, multi-agency State and local child fatality review teams for the purpose of preventing child deaths. Administrative support is to be provided by the CMCH.

Hereditary and Congenital Disorders Program (HEALTH GENERAL, Article 13, SS101) -- Establishes an Advisory Council and programs to address hereditary and congenital disorders. Administratively placed within the OGCSHCN.

General Regulations For Hereditary Diseases (COMAR 10.52.01) (several programs related to genetic disorders are mandated in regulation rather than statute)- Establishes quality assurance standards for hereditary and congenital disorders services procured by the State. These regulations are administered by the OGCSHCN.

Program for Hearing Impaired Infants (HEALTH GENERAL, Article 13, SS601) -- Establishes a program for universal hearing screening of newborns and early identification and follow-up of infants at risk for hearing impairment. This Program is administratively placed in OGCSHCN.

Sickle Cell Anemia (HEALTH GENERAL, Article 18, SS 501) -- Establishes a program for screening newborns for sickle cell anemia, monitoring each affected infant's health and providing prenatal education regarding sickle cell anemia. Informed consent is required for screening. This program is part of the bloodspot newborn screening and follow up program administered by the OGCSHCN.

Screening for Treatable Disorders in the Newborn Child (COMAR 10.52.12)-- Establishes a voluntary program to offer newborn screening for treatable metabolic disorders. Informed consent is required for screening. This program is administered by the OGCSHCN.

Screening for Sickle Cell Disease, Thalassemia and Related Conditions (COMAR 10.52.13)- Establishes a voluntary program for population based carrier screening for these conditions. This program does not include newborns or those thought to be at risk on clinical grounds. This program is administered by the OGCSHCN.

Screening for Neural Tube Defects in the Fetus (COMAR 10.52.14)-Establishes a program to offer biochemical maternal serum screening to identify mothers at increased risk for carrying a fetus with a neural tube defect or a chromosomal anomaly. This program is administered by the OGCSHCN.

Maryland Asthma Control Program (HEALTH GENERAL, Article 13, SS701) -- Establishes the Maryland Asthma Control Program within DHMH. The Program is administratively housed within CMCH.

Maternal Mortality Review Program (HEALTH GENERAL, Article 13, SS1201)-Establishes a program to review maternal deaths and develop strategies to prevent deaths. Support is provided by the CMCH.

Children's Environmental Health Advisory Council (HEALTH GENERAL, Article 13, SS501) -- Creates a Council which is charged to identify environmental hazards that may affect children's health and to recommend solutions. CMCH chairs and staffs the Council.

Lead Poisoning Screening Program (HEALTH GENERAL, Article 18, SS106) -- Establishes a Lead Screening Program to assure appropriate screening of children. This Program is administratively placed within CMCH.

Disease Prevention (HEALTH GENERAL, Article 18, SS107) -- Directs the Secretary to devise and institute means to prevent and control infant mortality, diseases of pregnancy, diseases of childbirth, diseases of infancy, and diseases of early childhood as well as to promote the welfare and hygiene of maternity and infancy. This mandate applies to programs administered within CMCH and OGCSHCN.

Sentinel Birth Defects (HEALTH GENERAL, Article 18, SS206) -- Requires hospitals to report sentinel birth defects to the Secretary. Also requires the Secretary to monitor birth defects trends. OGCHSN is administratively responsible for the program.
The program unsuccessfully sought to change this statute in the 2005 legislative session. Legislative change was sought to authorize the collection of data on all significant birth defects rather than just a few "sentinel " defects, bringing the program in line with CDC standards. The proposed change would also have clarified and strengthened the language allowing the program to access medical information related to the birth defect from medical records, again bringing the program up to CDC standard. Passed in the House of Delegates, the bill failed in the Senate because of a disagreement regarding the need for informed consent to access the names and addresses of possible controls for the purpose of informing them of a study and inviting their participation. Actual participation is always with informed consent and under IRB supervision. An amended bill will be proposed in the 2006 session.

School Health (EDUCATION, Article 7, SS401) -- Requires the Department of Education and the Department of Health and Mental Hygiene to jointly (1) develop public standards and guidelines for school health programs; and (2) offer assistance to the county boards and county health departments in their implementation. School health activities are housed within CMCH.

Program for Crippled Children (HEALTH GENERAL, Article 15, 125) - Establishes a program to identify and to provide medical and other services to "children who are crippled or who have conditions related to crippling". Administratively placed within the OGCSHCN.

Fetal and Infant Mortality Review (HEALTH GENERAL, Section 18-107) This activity is administratively placed within CMCH.

Lead Poisoning Screening Program - Implementation (COMAR 10.11.04) CMCH is administratively responsible for this Program.

Family Planning (Family Law Article, Section 2-405) The Family Planning Program is required to distribute a Family Planning brochure to all marriage license applicants.

CMCH is responsible for developing Perinatal Systems Standards which are incorporated in the following regulations:
COMAR 10.24.12 (State Health Plan: Acute Hospital Inpatient Obstetric Services)
COMAR 10.24.18 (State Health Plan: Specialized Health Care Services -- Neonatal Intensive Care Services)
COMAR 30.08.01 (MIEMSS -- Designation of Trauma and Specialty Centers)

Legislation passed during 2004 requires the Secretary of Department of Health and Mental Hygiene to establish and promote a statewide campaign on fetal alcohol syndrome and other effects of prenatal alcohol exposure. This activity is placed administratively in the Center for Maternal and Child Health.

MCH programs and services in Maryland are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs. Both CMCH and OGCSHCN work collaboratively to ensure that Title V funds are administered efficiently and according to best practice standards in public health.

The mission of the Center for Maternal and Child Health is to improve the health and well-being of all women, newborns, children and adolescents in Maryland. Ms. Bonnie S. Birkel serves as the Center's director. As the attached organization chart shows, the Center is comprised of five divisions: Family Planning and Reproductive Health; Maternal and Perinatal Health; Child and Adolescent Health; Community Based Initiatives and Partnerships; and Administration, Planning and Epidemiology. The Service System Development Initiative (SSDI), Asthma, and Early Childhood Systems Development, and Title X Family Planning grants are also administered by CMCH. Administrative changes at the federal level resulted in the transfer of administrative responsibility for the Abstinence Education Program from DHMH to the Department of Human Resources (DHR). However, DHMH petitioned the Governor and was able to maintain fiscal and administrative control for the Program.

The goal of the Family Planning and Reproductive Health Program is to improve the health of women of reproductive age by assuring that comprehensive, quality family planning and reproductive health care services are available and accessible to citizens in-need. The target population includes clients in need of subsidized family planning services, with special attention to those who are uninsured and with incomes under 250% of federal poverty guidelines. The Program is consistent with federal and state mandates to lower the incidence of unintended pregnancy and promote the health of women of reproductive age (Health General, Article 18, Section 107 of the Annotated Code of Maryland, and Title X of the U.S. Public Health Services Act of 1970). Program efforts are designed to (1) assure that Maryland communities offer family planning and reproductive health services to clients in need; and (2) develop a coordinated approach for assuring quality patient care services, educational activities, and evaluation efforts in order to improve reproductive health outcomes.

The Family Planning Program administers the following services: Family Planning Clinical Services, Reproductive Health Services that include colposcopy, cancer screening program and sexually transmitted disease treatment, the Healthy Teens and Young Adults program and the Adolescent Pregnancy Prevention Program. Program activities include the following:

1. Assuring reproductive health care to over 70,000 clients each year through a statewide network of over 80 ambulatory sites located in local health departments, outpatient clinics, community health centers, Planned Parenthood affiliates, and private provider offices;
2. Providing an array of preventive health care services including contraceptive care, colposcopy services, reproductive health education and counseling, sexually transmitted disease services, HIV/AIDS prevention services, breast and cervical cancer screening, cardiovascular risk screening, and referrals for indicated health and social services;
3. Developing community-based outreach strategies for reaching and serving young people, both males and females, who are at risk for unintended pregnancies;
4. Organizing workgroups of health professionals and community members to set standards for clinical care; and
5. Assuring compliance with Title X Federal Family Planning regulations and guidelines.

The goal of the Maternal and Perinatal Health Program is to prevent maternal and infant deaths and other adverse perinatal outcomes by promoting preconception health, assuring early entry into prenatal care, and improving perinatal care. In collaboration with local health departments, hospitals, private providers, professional organizations and community groups, the Program works to assure and improve the quality of services for the 70,000+ infants born each year in Maryland. This Program oversees the maternal health programs of the MCH Block Grant. The Program is consistent with federal and state mandates to reduce infant mortality and promote the health of women and children (Health General, Article 18, Section 107 of the Annotated Code of Maryland, and Title V of the U. S. Social Security Act of 1935). Program efforts are designed to improve the health of women of reproductive age and their newborns by assuring that comprehensive, quality maternal health care services, including outreach and education, are available and accessible to Maryland citizens in need. Program activities include the following:

1. Assuring access to maternal health services, including medical care, risk assessment, prenatal education, case management, smoking cessation counseling, genetic screening, high-risk referral,

home visiting, assistance in obtaining hospital-based services, and referral for family planning, and preconception health care;
2.Support of a Toll Free Maternal and Child Health Hotline (1-800-456-8900) that assists pregnant women seeking prenatal care;
3. Funding of regional perinatal improvement activities (Crenshaw Perinatal Health Initiative);
3. Perinatal systems building in each jurisdiction including Fetal and Infant Mortality Review, provider education, and public awareness efforts;
4.Development of perinatal standards and support for Perinatal Center Review and Designation;
5.Administration of the Pregnancy Risk Assessment Monitoring System (PRAMS), a statewide survey that identifies and monitors selected maternal behaviors;
6.Promotion of Preconception Health including the use of folic acid preconceptually (Folic Acid Council);
7.Breastfeeding Promotion in cooperation with the Maryland Breastfeeding Promotion Task Force;
8.Maternal Mortality Review in cooperation with the Vital Statistics Administration and the State's Medical Society;
9.Funding for Sudden Infant Death Syndrome (SIDS) related educational and family support activities;
10.Supporting state activities to identify and address Fetal Alcohol Spectrum Disorders (FASD);
11.Supporting state activities to address postpartum depression; and
10.Sponsoring Perinatal Health Conferences.

The goal of the Child and Adolescent Health Program is to promote and protect the health of Maryland's 1.5 million children and adolescents, ages 0-21, by assuring that comprehensive, quality preventive and primary services are available and accessible. This is accomplished through a comprehensive, integrated system of care that provides: (1) direct and enabling services to underinsured and uninsured children and (2) population based services to Maryland's children, adolescents and young adults who would be at risk if preventive public health measures and health messages were not available. The Program is responsible for developing policies and implementing primary prevention and early intervention strategies to improve the health of Maryland's children. Leadership, consultation, training and technical assistance are provided in several program areas including school and adolescent health, care coordination and home visiting, environmental health and child fatality review. The Program collaborates with numerous DHMH programs and other State agencies in the development of policies and programs. This Program also oversees the child and adolescent health components of the MCH Block Grant Program.

Programs administered by this Division include the School Health Program; the Asthma Control Program; the Childhood Lead Screening Program; and the Adolescent Health Program.

Program activities include the following:

1.Assuring access to child health services including medical care, risk assessment for families and adolescents, case management and home visiting, screening, referrals and assistance obtaining a medical home;
2.Facilitating the development of regional/community child and adolescent health plans;
3. Providing medical consultation and technical assistance to school health programs;
4. Teen pregnancy prevention;
5. Administering the Maryland Abstinence Education and Coordination Program;
6.Administering the Childhood Lead Screening Program and evaluating Maryland's Targeting Plan for Areas At Risk for Childhood Lead Poisoning to assure appropriate screening and testing of all children at risk for lead poisoning;
7.Implementing the Child Fatality Review (CFR) mandate including supporting the State Child Fatality Review Team;
8.Supporting the Children's Environmental Health Protection Advisory Council;
9.Administering the Maryland Asthma control program including implementation of both a statewide asthma plan and an asthma surveillance system;
10. Planning to prevent childhood overweight and obesity;
12. Support of state activities to reduce child abuse and neglect; and

11. Working with the Medical Assistance Program to increase enrollment in MCHP and other Medical Assistance Programs.

The goal of the Women's Health Program is to assess and address health issues that commonly, uniquely, or disproportionately affect women throughout their life span. This Program partners with other program areas to facilitate access to comprehensive preventive and primary care services that incorporate the unique needs of women. The Women's Health Program was established by issuance of an Executive Order in 2001. Funding was initially appropriated by the Legislature to staff the Office. However, this funding was cut due to fiscal constraints and staffing for the Program currently consists of one board certified obstetrician/gynecologist with in-kind support provided by other staff within CMCH. Program activities include:

1.Administration of the Women Enjoying Life Longer (WELL) Project, a former demonstration project funded under the MCHB grant program,"Integrated Comprehensive Women's Health Services in State MCH Programs." The goal is to integrate and coordinate preventive health services to promote wellness among women enrolled in family planning programs. CMCH has made the commitment to sustain funding for the WELL Project
2.Publication of materials to promote and improve the health of women. Current publications include a booklet on postpartum depression (www.fha.state.md.us/womenshealth/pdf/postpartum_booklet.pdf) and a report on the health of Maryland women (www.fha.state.md.us/mch/pdf/WomensHealth-Publication.pdf.)

The Division of Community Initiatives and Partnerships is responsible for developing initiatives and strengthening community partnerships with community organizations, advocacy groups, universities and professional groups to improve maternal and child health. This Unit shares responsibility with other programs where community involvement, outreach and partnering are crucial to program success. Examples include Abstinence Education, Pregnancy Risk Assessment Monitoring System (PRAMS), Teen Pregnancy Prevention, Male Involvement, and Child Fatality Review.

The Division of Administration, Planning, and Epidemiology supports Center activities at the infrastructure building level. A major Division goal is to track and monitor the health and health needs of women and children. Responsibilities include data and epidemiological analyses, statewide and community needs assessment, programmatic evaluations, strategic planning, MCH technical assistance/consultation, contract monitoring and analyses as well as fiscal/administrative and personnel related activities. This Division also administers the SSDI grant, and the Early Childhood Comprehensive Systems Development Grant as well as coordinates the development of multiple grants.

The mission of the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) is: (1) to reduce death, illness and disability from genetic disorders, birth defects, chronic diseases and injuries and to improve the quality of life for these individuals, and (2) to protect and promote the health of Maryland's children with special health care needs by assuring a family-centered, community-based, comprehensive, coordinated and culturally appropriate system of specialty health care. As the organization chart shows, the OGCSHCN is comprised of six divisions: Newborn Blood Spot Screening and Follow-Up, Newborn Hearing Screening Follow- Up, Birth Defects, Metabolic Disease Nutrition, and Specialty Care and Regional Resource Development and Program Support.

The Division of Newborn Screening and Follow-Up screens babies for 32 disorders. The disorders are: 3 amino acid disorders (PKU, homocystinuria, and tyrosinemia), 3 urea cycle disorders, 13 disorders of organic acid metabolism (including MSUD and Biotinidase Deficiency), 9 disorders of fatty acid metabolism, Galactosemia, Congenital Adrenal Hyperplasia, Hypothyroidism, and Sickle Cell Disease. All babies born in Maryland, (70,000+ per year), are eligible for service. This Division also includes Carrier Screening for sickle cell disease, Thalassemia and Tay-Sachs Disease as well as AFP/triple Marker Screening to detect neural tube defects.

The Division of Newborn Hearing Screening Follow --Up is supported by a grant from MCHB. This

Division has been severely short staffed for the last several years. The Division lost its Chief in 2003 and was unable to replace him because of a hiring freeze. The junior audiologist left in 2004. The Division was folded into the bloodspot screening program to assure continued service to the babies of Maryland. However, an exception to the hiring freeze was obtained, 2 audiologists are being recruited and the Division should be able to operate independently again.
The Division of Metabolic Disease Nutrition follows patients with genetic metabolic disorders like PKU or MSUD and provides case management, dietary therapy and a summer camp.

The Birth Defects Division includes the Birth Defects Reporting and Information System, which collects data on the number of babies born with any of 12 common birth defects and provides information on the defects and services available. The Chief of the Birth Defects Reporting and Information System in the OGCSHCN is also the mother of a child with a birth defect and adds a mother's perspective to that program. The Department will return to the Legislature in 2006 to seek legislative change to broaden the scope of the program's data collection and to strengthen and clarify its authority to access information from medical records.
The Division of Specialty Care includes the Children's Medical Services Program (CMS), the Regional Resource Development Program, the Medical Day Care Program, and the Genetic Services Program. The Children's Medical Services Program (CMS) had historically served as the payer of specialty services for a large population of children with special health care needs in the state, serving over 12,000 children at its peak. Over the last 8 years, the need and demand for this program has been quite variable and the program has undergone major changes. The expansion of Medicaid in the 1990s lessened the need for the program as most CMS patients became eligible for other programs. The program was redesigned and funds redirected to care coordination, other enabling services, systems development and the dissemination of information about the services available. In the last few years, the program served a small number of children (135 in FY 2004), most of whom were undocumented. However, the FY 2006 state budget eliminates Medicaid eligibility for approximately 3,000 children who are legal immigrants but who have not lived in Maryland for a minimum of 5 years. It is anticipated that the children with special health care needs in that group will seek fee for service coverage for their specialty care from the CMS program. This could potentially increase the caseload in the CMS program by 450 children or roughly a factor of four.
The Regional Resource component of OGCSHN funds 21 of the state's 24 local health departments in FY 2005 for a variety of services including the provision of specialty clinics for uninsured and underinsured children, care coordination, respite care, assessment of family and community needs and service capacity building. The scarcity of specialty providers willing to accept Medicaid rates in the outlying areas of the state and the failure of local hospital specialty clinics to break even, lead the Maryland Association of Local Health Officers to request a re-expansion of the old statewide system of outreach specialty clinics in 2004. Currently, six jurisdictions receive funds to partially support specialty clinics. Twelve (12) jurisdictions receive funds to support case management and care coordination. The need for respite care was mentioned in the needs assessment reports from most local health departments. Sixteen jurisdictions are currently (FY 2005) receiving funding for respite care.

Two Medical Child Care Centers are funded to serve children ages six weeks to three years of age with complex medical conditions and medical needs that cannot be met in traditional child/day care programs. As part of the interagency collaboration with Maryland's Early Intervention System, staff are involved in interagency coordination and liaison activities.
Finally, the Genetic Services Program coordinates a statewide network of clinical genetic services at 3 centers, and 13 general genetics outreach clinics. The clinic system is constantly rearranged to better serve the population in accordance with changing demographics in the state. Special genetics outreach clinics for facial clefts, hemophilia and sickle cell disease are conducted when there is need for them.

The Community Health Administration also administers a portion of Title V State matching dollars that are allocated to the local health departments through targeted funding. Maryland's 24 local health departments provide the core public health functions of assessment, policy development and assurance to citizens at the local level. The 24 local health departments receive annual basic public

health funding (including Title V funds) from the DHMH through a Unified Grant Award process. Local health departments are the major service delivery arm for the DHMH and provide MCH services such as school health, family planning, home visiting and care coordination, immunizations, lead screening, fetal and infant mortality review, child fatality review, oral health services and maternal health services. Health Officers in each of Maryland's 24 jurisdictions are responsible for administering state and local health laws and regulations.

C. ORGANIZATIONAL STRUCTURE

The State of Maryland, Department of Health and Mental Hygiene (DHMH) is the designated Title V Agency. The Secretary of Health and Mental Hygiene, Mr. S. Anthony McCann, heads DHMH and reports directly to Governor Robert L. Ehrlich. Mr. McCann replaced Nelson Sabitini as the Secretary in September 2004. As the attached organizational chart shows, three Deputy Secretariats report to Mr. McCann: (1) Operations, (2) Public Health Services and (3) Health Care Policy, Finance and Regulations.

The Title V Program is administratively housed under the Family Health Administration within the Deputy Secretariat for Public Health Services. This Deputy Secretariat is responsible for six other administrations: AIDS, Alcohol and Drug Abuse, Community Health (e.g., Immunizations, sexually transmitted diseases, and bioterriorism), Developmental Disabilities, Laboratories, and Mental Hygiene; as well as the Anatomy Board and the Office of the Chief Medical Examiner. Medical Assistance, the State's Medicaid Program, is located under the Health Care Policy, Finance and Regulation Secretariat. The Deputy Secretariat for Public Services is headed by Dr. Michelle Gourdine.

The Family Health Administration (FHA) was formed in July 2001 and has been headed by Dr. Russell Moy as its Director and Ms. Joan Salim as the Deputy Director since its inception. FHA oversees a diverse array of public health programs within eight offices and two chronic rehabilitative facilities. The target population includes Maryland's total population of 5.5 million people, covering the lifespan from pregnancy to adulthood. Within the total population, at risk and vulnerable populations including low income, uninsured and medically underserved populations, are programmatically identified and safety net services provided.

All of the MCH related programs are located within the FHA. The Family Health Administration includes the Center for Maternal and Child Health, the Office for Genetics and Children with Special Health Care Needs, the Office of Primary Care and the WIC Office. Other offices within the Administration closely linked with the core MCH offices are the Center for Preventive Health Services which recently gained administrative responsibility for the Office of Oral Health; Health Promotion, Education and Tobacco Control; and the Office of Health Policy. Department organization charts identifying the programs at the Secretariat and FHA levels are attached.

D. OTHER MCH CAPACITY

Maryland's MCH Program includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. This team plans, manages, and monitors Title V activities for Maryland from the Downtown Baltimore offices of Maryland's State Office Complex. In addition, MCH staff in local health departments, including a cadre of community health nurses, physicians, program administrators and clerical personnel, are also supported by Title V funds.

The Center for Maternal and Child Health is headed by Bonnie S. Birkel, CRNP, MPH. Ms. Birkel is a trained nurse practitioner with a Master of Public Health degree and 25 years of experience in public health. She is responsible for MCH policy development and is official spokesperson for all MCH and family planning related areas. She has served as CMCH's Director since its inception in 2000.

Susan R. Panny, M.D., oversees the work of the Office for Genetics and Children with Special Health Care Needs. Dr. Panny is certified by both the American Board of Pediatrics and the American Board of Medical Genetics. She has 30 years of experience in pediatrics and genetics and 20 years of experience in public health. She is an internationally known figure in newborn screening and public health genetics. She has served as the Director of the OGCSHCN since 2000, and prior to that had served as Director of the Office for Hereditary Disorders since 1984.

Maureen Edwards, M.D., M.P.H., serves as Medical Director for CMCH. Dr. Edwards holds board certification in neonatology and a masters degree in public health. Her prime responsibility is to oversee and provide medical consultation on policy and assurance matters for various CMCH programs. She is also the Center's legislative liaison. Dr. Edwards supervises the Center's medical staff, including the Medical Director for School and Adolescent Health, Dr. Cheryl DePinto, who is board certified in pediatrics and adolescent medicine; the Medical Director for the Family Planning Program, Dr. Evan Mortimer, a board certified obstetrician/gynecologist; and the Medical Director for Women's Health, Dr. Diana Cheng, a board certified obstetrician/ gynecologist.

Jamie Perry, M.D., M.P.H. serves as the Associate Medical Director of the Office for Genetics and Children with Special Health Care Needs. Dr. Perry is board certified in Pediatrics and Neurodevelopmental Disabilities and holds a Master of Public Health Degree. Dr. Perry assists Dr. Panny in overseeing the clinical and programmatic work of the OGCSHCN, with particular focus on programs in the Division of Specialty Care.

Ngozi Nwokoro, PhD, MD was hired as a temporary consultant to the Office for Genetics and Children with Special Health Care Needs to assist with the expansion of newborn screening. Dr Nwokoro has a PhD in biochemistry, is board certified in Pediatrics and has completed fellowships in clinical genetics and biochemical genetics.

Donna Harris, BS, serves as Special Assistant to the Director and Associate Director. Ms Harris is setting up a data tracking system for programmatic service data. She handles data requests and produces special reports. She is in charge of OGCSHCN internal policies and assuring that OGCSHCN is in compliance with Departmental, State and federal policies. She prepares reports documenting OGCSHCN compliance with all policies.

In the CMCH, Bernadette Albers, M.P.H., APRNCS, assists Ms. Birkel as the Assistant Director of CMCH. Ms. Albers holds a Master of Public Health degree and is board certified in community health nursing. She has over 25 years experience in the fields of public health and health administration. In addition to being responsible for CMCH's daily operations, she heads the Division of Administration and Planning. This unit includes a master's trained health policy/research analyst who serves as the SSDI Project Director and Title V Coordinator (Yvette McEachern); a database administrator (Debbie Walpole); a master's trained asthma program administrator (Audrey Regan); a master's trained early childhood administrator (Mary LaCasse) and support staff (Debbie Krome and Anita Goldman).

Until recently, this unit included four master's trained nurse consultants; however, two of them retired in the past year. The remaining two nurse consultants, Jeanne Brinkley and Pamela Putman, are responsible for monitoring local health department MCH contracts and providing technical assistance and consultation to Title V grantees on MCH issues (e.g., lead, adolescent health, asthma, obesity, school health). Ms. Brinkely supervises the MCH Coordination unit and the Department's lead staff person for lead activities. Ms. Putman also serves as the state's adolescent health coordinator. CMCH recently lost its fiscal administrator due to retirement. The Office is currently considering several options for filling this crucial vacancy.

Planning, evaluation and data analysis activities are provided by a MCH epidemiologist, a MCH database specialist, a health analyst, the Assistant Director for MCH and the birth defects database specialist and nurse consultants in the OGCSHCN. Yvette McEachern, M.A. has served as the SSDI Project Director for the past three years and also oversees development of the Title V application including data collection performance monitoring and needs assessment. Ms. McEachern has over 20 years experience as a health analyst/statistician at the State level. Debbie Walpole, B.S. serves the MCH database manager/specialist and oversees CMCH database development and linkages; and data generation using SAS and other software. Bernadette Albers leads strategic planning efforts for the MCH Program and supervises grants development, including Title V.

William Adih, M.D., Dr.P.H. is a senior MCH epidemiologist with the Title V Program. Dr. Adih is a public health physician with extensive domestic and international experience in maternal and child health and reproductive health epidemiology. He provides epidemiological and data analysis support for the Center's activities.

Debra Perry, MPH was hired for a newly created Title X funded position of Family Planning Epidemiologist. Ms. Perry received her MPH from the University of Michigan School in of Public Health in Epidemiology and has worked provided epidemiologic support to various state and local agenices in Virginia and Maryland.

In addition, data support and analysis is provided by the Vital Statistics Administration which is headed by an MCH epidemiologist, Dr. Isabelle Horon, and the Office of Injury Prevention and Public Health Assessment which is headed by Dr. Lori Demeter. Contractual services are also purchased when necessary to complete data, assessment and planning activities.

Andy Hannon, LCSW-C, supervises the Division of Community-Based Initiatives and Partnerships. Mr. Hannon has over 25 years experience in public health and in addition to his supervisory role, leads male involvement initiatives for CMCH. Other activities under his direction include implementation of the PRAMS Survey which is supported by three staff persons (Helen Espatillier, Laurie Kettinger and Jodi Shaefer); and the Abstinence Education Program. The Abstinence Education Coordinator position is currently vacant and interviews have been held to select a new coordinator. This position serves as the Teen Pregnancy Prevention Coordinator for CMCH. Ms. Mary Johnson provides staff support to the Maryland Breastfeeding Promotion Task Force, and the Children's Environmental Health and Protection Advisory Council. Ms. Johnson also leads community outreach efforts for CMCH. Joan Patterson, LCSW-C, was hired by Mr. Hannon as the CFR/FIMR Coordinator. She provides staff support to the State Child Fatality Review Team, and monitors contracts that provide technical support to local CFR and FIMR teams.

The Title X Maryland Family Planning Program links and overlaps with MCH on a number of issues including preconception health care, teen pregnancy prevention and infant mortality reduction. The Family Planning staff include a Program Chief, a Medical Director, several physicians, several nurse practitioners who provide direct medical services and monitor contracts and program quality, and a program administrator. Ms. Victoria Young, LCSW-C, was hired the Chief of Family Planning in January 2003. Ms. Young has worked extensively in the area of child abuse and neglect.

In the OGCSHCN, Lynne Kelleher serves as chief of Program support. She serves as the Chief Fiscal Officer and as the Procurement Liaison for the Office. Sharon Burke handles contracts and assists with procurement. Barbara Greer handles personnel issues in addition to her role in the CMS program. General support services are provided by Marie Sapp, Terri Smiley and Chevria Meekins.

The Division of Newborn Screening is directed by Karen L. Funk. BS, RN, MEd. Ms. Funk has 35 years of neonatal intensive care nursing experience, 10 of them in a research setting. She provides the medically expert follow up for infants with abnormal blood spot screening results. She is also responsible for the major database of the OGCSHCN, which contains the linked data for the newborn blood spot and hearing screening programs, the long term follow up programs for sickle cell disease and metabolic disorders. She is assisted in the sickle cell disease program by Adi Bello, BSN, RN

who provides home visiting and clinical follow up and Marcia Diggs who handles the sickle cell disease follow up database. Chevria Meekins provides the specialized clerical support for this program.

The Newborn Hearing Screening Program lost both its audiologists but two new audiologists are very close to being hired. The senior audiologist will serve as Chief of the Division of Newborn Hearing Screening Follow-Up. The junior audiologist will provide the expert audiological follow up of babies suspected of having hearing loss. Theresa Thompson, BA, MA and Carol Fernandez, BA provide initial follow up of hearing screening results and handle the educational aspects of the infant hearing screening program. Eileen Cohen, BA, MA, CCC-SP, a speech pathologist who is the OGCSHCN Early Intervention specialist and liaison with Medicaid, provides consultation to the hearing screening program. Chevria Meekins provides the specialized clerical support for this program.

Elizabeth Emerick, BA, MS, RD, LN and Mary Kalscheur, BA, MS, RD, LN are expert metabolic nutritionists, each with over 20 years of experience, and provide the dietary therapy and long term case management for children with metabolic disorders.

Anne Terry, BSN, MA, RN, serves as the Chief of the Birth Defects program, and is assisted by Rosemary Baumgardener, BA who serves as database manager.

Patricia Williamson, BSN, RN, CCM provides the clinical expertise for Children's Medical Services, the fee for service portion of the CSHCN program. Ms Williamson has 15 years of experience working with CSHCN and their families. Barbara Greer is the CMS eligibility specialist and Terri Smiley provides the specialized clerical support to this program. Joanne Johnson handles billing and assists Ms. Kelleher with the fiscal management of the Office.

Mary Ann Kane- Breschi, BA is the CSHCN regional resources coordinator and the liaison with the teaching hospital "Centers of Excellence", the local health departments, Parent's Place and other CSHCN family support services. Eileen Cohen oversees this portion of the program and directs the medical day care program.

Maryland's Title V program is committed to family involvement as an integral component of MCH planning and programming. This is exemplified by the well established parent support groups developed by the OGCSHCN and the continued grant support for Parents' Place to provide outreach, communication linkages (newsletters) and consultation to the MCH Offices on CSHCN. The OGCSHCN has two professional staff members who are mothers of CSHCN.

E. STATE AGENCY COORDINATION

State Agency Coordination

The attached organization charts identify the functions and staff that support Maryland's Title V Program. In addition, both MCH offices, CMCH and OGCSHCN, maintain strong collaborative relationships with other MCH serving agencies both within and outside of DHMH to support MCH service delivery and infrastructure. Within DHMH, strong partnerships and collaborations have been forged with key agencies directors and their staff. FHA partners include the Office of Health Policy (which now includes the federal Primary Care Cooperative Agreement), the Office of Primary Care and Rural Health, the Center for Preventive Health Services, the Women, Infants and Children's (WIC) Program, the Office of Health Program and Tobacco Use Prevention), the Center for Cancer Surveillance and Control and the Office of Oral Health.

Work on MCH issues and needs will continue to be coordinated with a number of key state agencies outside of DHMH either through collaboration on joint initiatives or through committees, task forces and advisory groups. These agencies include the Governor's Office for Children (formerly the Governor's Office for Children Youth and Families), the Maryland Department of Human Resources, the Maryland State Department of Education, the Department of Juvenile Services, the Maryland

Institute of Emergency Medical Services, the Maryland Department of the Environment (MDE), and the Department of Housing and Community Development.

For example, several state agencies are responsible for planning and implementation of activities to eliminate elevated blood lead levels in Maryland children. MDE took lead responsibility for convening an Elimination Plan Working Group with representatives of state and local agencies (including DHMH), non-profits and community groups. A Maryland Plan to eliminate childhood lead poisoning by 2010 was developed. The Governor's Lead Commission on which CMCH is represented will oversee progress on Plan implementation.

Intra-agency and interagency collaboration will also continue with the following DHMH agencies and programs: the State Medicaid Agency, the Mental Hygiene Administration, the Laboratories Administration, the AIDS Administration, the Community Health Administration (including the Center for Immunizations), the Developmental Disabilities Administration, and the Maryland Health Care Commission.

MCH representation on numerous interagency councils, task forces, and committees will continue. These include the Coalition to End Childhood Lead Poisoning, the Governor's Lead Commission, the Promoting Safe and Stable Families Preservation Steering Committee, the Infants and Toddlers State Interagency Coordinating Council, the Maryland State School Health Council, various committees of the Maryland Chapter of the American Academy of Pediatrics, the Department of Human Resources Child Care Administration's Advisory Committee, Department of Human Resources' Responsible Choices Task Force, the Advisory Council for Hereditary and Congenital Disorders, the Advisory Council for Hearing Impaired Infants, the Advisory Board of Cooley's Anemia foundation of Maryland, the Sickle Cell Disease Association of America, Neurofibromatosis Inc.-Mid Atlantic, the Maryland Alliance of PKU Families and the Maryland Hemophilia Foundation.

The private sector includes an array of birthing hospitals and centers as well as office-based obstetrical, pediatric, and primary care providers, managed care organizations, federally qualified health centers, and rural health networks. Specialty care needs are addressed through a network of community-based providers, tertiary care centers (''Centers of Excellence''), a genetics network, the Crenshaw network, and linkages with the Shriner's Hospital through the MCHB sponsored Choices Program.

The Title V agency will continue to strengthen its working relationship with non-governmental organizations including: the Medical and Chirurgical Society of Maryland (Med-Chi), the Maryland Chapter of the American Academy of Pediatrics, the American College of Medical Genetics, the Maryland Ob-Gyn Society, the University of Maryland Schools of Medicine, Dentistry, Nursing and Social Work, the Johns Hopkins School of Medicine, the Johns Hopkins School of Hygiene and Public Health, the Maryland Association of HMOs, Planned Parenthood of Maryland and Metropolitan Washington, the Maryland Hospital Association, the Maryland Association of County Health Officers and numerous other local voluntary and communication based organizations.

MCH programs have strong collaborative partnerships with several teaching hospitals/universities in the state. Both JHU and UMAB have collaborated in the development of state and multi state conferences, and the design of research projects. The GWU School of Public Health and the Johns Hopkins School of Public Health have established an internship relationship where graduate preventive medicine fellows, MPH candidates and/or nurse practitioners have practicum experience in the MCH offices. In addition, the Chief of Clinical Nursing at GWU serves as the liaison to Ryan White Title II and IV committees. Johns Hopkins Hospital, the Kennedy- Kreiger Institute, the University of Maryland Medical Center and Children's National Medical Center partner with the OGCSHCN to deliver clinical genetic services as well as specialty care.

The Title V agency will continue to support community-based organizations that have been working to improve the health of mothers and children, including the Maryland Coalition for Healthy Mothers and Healthy Babies, the Maryland Perinatal Association, the Maryland chapter of the national March of

Dimes Birth Defects Foundation, the Latino Community Health Care Access Coalition and numerous single disease oriented voluntary organizations.

The Latino Community Health Care Access Coalition is a project of various Latino community groups, Catholic Health Care Initiatives, St. Clare's Medical Outreach, and St. Joseph Medical Center. Coalition members include the Highlandtown Medical Center, Johns Hopkins Bayview, Johns Hopkins Hospital, numerous Spanish speaking physicians in private practice and the Department of Health and Mental Hygiene, represented by Dr. Susan Panny of OGCSHCN. The goal is to assure access to high quality culturally competent health care for the Latino Community.

Other examples of collaborative efforts follow:

Inter-agency efforts with the WIC Program include the Maryland Breastfeeding Task Force and the Folic Acid Council. WIC and CMCH jointly co-chairs each of these groups. The March of Dimes is also an active participant in the Folic Acid Council. A grant from the March of Dimes to the MCH Program allowed for the re-institution of the Folic Acid Council in 2003.

The Office of Oral Health (OOH) which was recently merged with the Center for Preventive Health Services has developed a strong collaborative relationship with the MCH Offices. The CMCH Assistant Director continues as an active consultant to the Statewide Oral Health Advisory Committee. This Committee is currently overseeing the completion of a study of Maryland's oral health infrastructure. The OOH works collaboratively with the Medicaid Program to complete an annual legislatively mandated assessment of use of oral health services .

Collaboration has been strengthened between the MCH program and the Family Health Administration's Center for Preventive Health Services on the issues of asthma, childhood obesity and women's health. In addition, the CMCH and Center on Health Education and Tobacco Prevention continues to partner with MCH, ACOG, and local health departments on smoking cessation initiatives during pregnancy.

The Title V Programs collaborate with other DHMH agencies on a number of priority MCH issues and needs. Intra-agency and inter-agency collaboration will continue with the following DHMH agencies, and programs: the State Medicaid Agency, the Mental Hygiene Administration, the Laboratories Administration, the AIDS Administration, the Community Health Administration (including the Center for Immunizations), the Developmental Disabilities Administration, the Vital Statistics Administration, Children's Environmental Health and Protection Council, the Office of the Chief Medical Examiner, and the Maryland Health Care Commission.

Maryland's Medical Assistance Program provides all the resources and personnel necessary to implement HealthChoice and MCHP. A collegial and collaborative relationship exists between this Program and the MCH Offices. A revised Memorandum of Agreement (MOA) was finalized in 2004. The MOA speaks to sharing of client databases between each unit, and access to information on Medicaid eligibility status. Examples of collaborative efforts include the drafting of the adolescent health section of the state's EPSDT Manual by two CMCH staff persons, the Medical Director for School and Adolescent Health, and the state's adolescent health coordinator.

The OGCSHCN Early intervention specialist, who is a speech pathologist, spends two days a week with Medicaid preauthorizing OT, PT, audiological services, speech therapy and hearing aids. The OGCSHCN, particularly the CMS program, and Medical Assistance cross- refer patients that may be eligible for each others programs. The Medical Assistance information management staff produces reports of expenditures per child in the CMS program, broken down by county of residence and category of expense.

The new Interagency Agreement for Part C between the Department of Health and Mental Hygiene and the Maryland Department of Education includes a section on the exchange of data between OGCSHCN ‘s Newborn Hearing Screening Follow-Up program and the Division of Special Education/

Early Intervention to improve the referral process of hearing impaired infants to the Infants' and Toddlers' Program and to obtain long term outcome data on hearing impaired children identified through the newborn hearing screening program.

The Center for Immunization within the Community Health Administration developed a strong collaborative relationship with the Division of Child and Adolescent Health to improve childhood immunization rates. MCH is represented on the Maryland Immunization Partnership Committee.

Mental health related issues and concerns such as improving access to services are critical to health of women, children and families in Maryland. The Title V Program has grappled with its role in this area and continually seeks opportunities to partner with other state and local agencies, advocacy groups, and community based organizations to improve the mental health of Marylanders. Mental health partners including child and adolescent health professionals in the Mental Hygiene Administration and the Mental Health Association were strategically involved in the latest statewide MCH needs assessment.

In May 2004, the Center for Maternal and Child Health in collaboration with the Mental Health Association of Maryland, Inc. submitted an application for the HRSA Grant entitled - Perinatal Depression and Related Mental Health Problems in Mothers and Their Families. Recent Maryland PRAMS data for 2003 indicate that at least 18% of new moms report being moderately or severely depressed following pregnancy. The state sought grant funds to implement a comprehensive public information and provider information campaign to increase understanding of perinatal depression and to address the stigma of mental illness which often discourages individuals from seeking treatment. Although the grant was not funded, educational materials including a postpartum depression brochure has been distributed widely throughout the state and requests for copies from other states have been honored. The MCH Program also partners with the State's Medical Society and the American College of Obstetricians and Gynecologists (ACOG) on postpartum depression.

The MCH Program continued as an active participant on the Early Childhood Mental Health Steering Committee. This inter-agency Committee was jointly convened by the Mental Hygiene Administration in DHMH and the Maryland Department of Education to develop a plan for incorporating mental health services into early childhood programs statewide. Both the Medical Director of CMCH and the Early Childhood Health Administrator are members. The state adolescent health coordinator is an active member of the planning committee for the Mental Hygiene Administration's annual statewide adolescent suicide prevention conference. CMCH is also an annual financial supporter of the conference.

Asthma is one the major causes of morbidity for Maryland children. Since 2001, CMCH has been administratively responsible for the state's CDC funded Asthma Grant which includes statewide asthma control planning and surveillance. With the completion of the Maryland Asthma Control Plan in 2004, the Maryland Asthma Planning Task Force evolved into the Maryland Asthma Coalition. The Coalition meets quarterly, and advises the state on implementation of CDC funded asthma control activities for both children and adults. Coalition membership includes representatives of the clinical community (e.g., Johns Hopkins and University of Maryland Schools of Medicine), public health agencies at all levels (e.g., DHMH Center for Preventive Health Services), health organizations (e.g., Maryland Lung Assocation), physician organizations (e.g., American Academy of Pediatrics) community health centers, and educational authorities.

In the area of early childhood health, the MCH Program has also been represented on the following interagency groups: the Healthy Child Care Maryland Steering Committee, the Maryland Girl's Commission, the Healthy Homes Initiative, the Early Childhood Mental Health Steering Committee, the Ready at Five Strategic Planning Committee, The Judy Center Advisory Committee, the Maryland Home Visiting Collaborative, and TAMAR's Children (an intervention program for incarcerated women and their children that addresses infant bonding and attachment issues).

Since 2003, the MCH Program has been an active participant on the Leadership in Action Program

(LAP) Team. This Team was convened by the Maryland Partnership for Children (includes the Secretaries of Health, Education and Human Resources) to address collaboration on early childhood issues in Maryland. MCH was also represented on the Early Head Start Policy Council and the Head Start Health Collaborative. MCH is also represented on the Maryland Developmental Disabilities Council, the Governor's Caregiver Support Coordinating Council, the Taskforce on Inclusive Child and After-School Care, and the Special Needs Advisory Council for HealthChoice and the Latino Community Health Care Access Coalition.

Several bills introduced during the 2004 Legislative Session would have required Maryland hospitals to provide written information to new parents on postpartum depression and shaken baby syndrome. The bills failed, however, and the Maryland Hospital Association subsequently convened an Ad Hoc Committee to determine how best to distribute this information to families of newborns. Both the CMCH Director, Bonnie Birkel and the CMCH Medical Director, Maureen Edwards are members of this Committee along with representatives from local hospitals and the Mental Health Association. The Title V Program is also represented on a statewide group that is developing a plan to address Fetal Alcohol Spectrum Disorders (FASD).

Maryland's Title V program is committed to family involvement as an integral component of MCH planning and programming. This is exemplified by the well established parent support groups developed by the OGCSHCN and their ongoing grant support of Parents' Place to provide outreach, communication linkages (newsletters) and consultation to the MCH Offices on CSHCN. The grants to Parent's Place also support a network of CSHCN parent representatives throughout the state. The OGCSHCN partnered with Wicomico County to establish a regional resource center in Wicomico County. The center serves the entire Eastern Shore and is a model for other regions. The center provides books, periodicals and internet access to information relevant to CSHCN and enables parents to access these resources and to link with other parents.

The OGCSHCN has two professional staff members who are mothers of special needs children and who bring the family perspective to the program. One serves as Chief of Regional Resource Development and the second is Chief of the Birth Defects Reporting and Information System.

Finally, the Title V Program will continue to chair and/or staff the following inter-agency advisory boards, councils and committees: the Perinatal Clinical Advisory Committee, the Perinatal Disparities Work Group, the Maryland Breastfeeding Promotion Task Force, the Early Childhood Health Advisory Committee, the Children's Environmental Health and Protection Advisory Council, the Asthma Coalition, the Women's Health/PRAMS Advisory Committee, the State Child Fatality Review Team, and the Abstinence Education and Coordination Advisory Committee.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Below is a narrative description of Maryland's status on the required Health System Capacity Measures and Health Status Indicators. Data for each of the indicators is included on Forms 17, 18 and 19.

Health System Capacity Measure #01 -- The rate of children hospitalized for asthma per 10,000 children less than five years of age.

Following the receipt of a CDC grant in 2001, Maryland began implementation of a statewide asthma surveillance system and development of a statewide asthma control plan. To date, three asthma surveillance reports have been completed for the years 2002-2004. The 2004 Maryland Asthma Surveillance Report indicates that statewide, an estimated 153,172 children have been diagnosed with asthma at some point in their lifetime. This represents 11.1% of children. An estimated 188,673 children (8.6%) currently have asthma.

Children under the age of 5 had the highest hospitalization rate of any age group at 45.0 hospitalizations per 10,000 population in 2003. Maryland's rate was lower than the national average in

2003, but higher than Healthy People 2010 goal of 25 hospitalizations per 10,000.

Hospitalization rates for African Americans in 2003 were three times that of Whites. The emergency department visit rate was four times higher for African Americans as compared to Caucasian Americans.

The Statewide Asthma Control Plan completed in April 2004 identifies strategies for promoting proper outpatient management of asthma and decreasing inappropriate hospitalizations. The Title V Program administers a three year CDC asthma control grant.

Health System Capacity Measure #02 -- The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

Data for this indicator is provided by the Medicaid Program. Increasing percentages of infants enrolled in Medicaid are receiving at least one periodic screen. In Federal Fiscal Year 2003, over 90% of the 31,778 infants enrolled received a screen; up from 75% in FFY 1999.

Most infants are enrolled in HealthChoice, Medicaid's managed care program which began in 1997. Medicaid recipients enroll in a managed care organization of their choice and select a primary care provider to oversee their medical care. The HealthChoice Evaluation data for 2005 indicates that the percentage of infants (includes those enrolled in both traditional Medicaid and MCHP) receiving a well child visits increased between 2000 and 2003, from 69.2% to 79.4%. Well child visits were defined by Medicaid to include well child visits, EPSDT and preventive services.

Health System Capacity Measure #03 -- The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen

Maryland's SCHIP Program, the Maryland Children's Health Program (MCHP), provides full Medicaid health benefits to children up to age 19, and pregnant women of any age who meet the income guidelines. MCHP enrollees obtain care from Managed Care Organizations (MCOs) through the Maryland HealthChoice Program. The Medicaid Program reports that in FFY 2003, 91.4% of the 395 infants enrolled received at least one periodic screen.

Health Systems Capacity Measure #04 -- The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index

Maryland is not submitting data for the two indicators that require calculation of the Kotelchuck Index. As in past years, the MCH Program requested this data from the Vital Statistics Administration, but because of concerns about the formula used to calculate the Index, the information was not provided. The formula defines the first trimester of pregnancy as months one through four. Traditionally, the first trimester is defined as months one through three.

Health Systems Capacity Measure #07 -- The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

These data are provided by the Maryland Medicaid Program and show that increasing percentages of EPSDT eligible children have been receiving dental services. However, the percentages remain low, less than 50%, and the Maryland Legislature continues to monitor the Program's plan for increasing utilization rates.

In 2003, 43.2% of children, ages 4-20, received one more dental services -- mainly diagnostic and preventive services. Only 13.6% received restorative services in that year. Increasing number of

dentists in the state are accepting Medicaid clients, 330 dentists as of July 2004. However, dental provider shortage areas continue to exist and some dentists provide limited services to Medicaid clients.

Health Systems Capacity Measure #08 -- The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

As of December 2003, according to the Social Security Administration, there were 12,172 Maryland children under the age of 16 receiving federally administered SSI payments. In 2003, none of these children received rehabilitative services from the State CSHCN Program since all qualified for these services through the Medicaid/MCHP Program. Medicaid/MCHP covers children up to 200% of the poverty level, the same income eligibility guidelines as Medicaid. Medicaid coverage in Maryland includes rehabilitative services.

Health Systems Capacity Indicator #05 -- Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the state.

Data for this indicator is largely derived from birth and infant death records for 2003. As was true in previous years, the data indicate that Medicaid enrolled women as compared to women with other types of insurance are significantly more likely to have a baby die within the first year of life, less likely to receive early prenatal care and more likely to have a low birth weight baby.

Maryland is not submitting data for the two indicators that require calculation of the Kotelchuck Index. As in past years, the MCH Program requested this data from the Vital Statistics Administration, but because of concerns about the formula used to calculate the Index, the information was not provided. The formula defines the first trimester of pregnancy as months one through four. Traditional definitions define the first trimester as months one through three.

Health Systems Capacity Indicator #06 -- The percent of poverty level for eligibility in the State's Medicaid programs for infants, children, Medicaid and pregnant women.

The Maryland Medicaid Program provides medical care coverage to low income infants, children and pregnant women. Pregnant women and infants are covered up to 185% of the poverty level. Children under the age of 19 are covered up to 100% of the federal poverty level. In FY 2003, Children and adolescents under the age of 21 represented approximately 66% of Medicaid enrollees, but only 21% if expenditures. The majority of children are enrolled in HealthChoice, Medicaid's managed care program.

Health Systems Capacity Indicator #06 -- The percent of poverty level for eligibility in the State's SCHIP programs for infants, children, Medicaid and pregnant women.

Medicaid eligibility coverage extends to pregnant women and infants with family incomes up to 185% of the poverty levels. Coverage for children and adolescents extends to families with incomes up to 100% of the federal poverty level (FPL).

Maryland's state only MCHP Program provides coverage to eligible women with family incomes up to 250% of the poverty level. Children in families with incomes up to 200% of the poverty level are eligible for MCHP. The MCHP Premium Program provides coverage to uninsured children and adolescents children up to age 19, who have not dropped employer-sponsored health insurance within the previous six months, and who have paid the monthly premium payment per family. The family income standard for eligibility is at 200% through 300% of the FPL. Premiums vary by family size and income and range from $41 to $52 per month. For both, MCHP and MCHP Premium, assets are not considered in determining eligibility. In addition, MCHP and MCHP Premium beneficiaries receive health benefits through HealthChoice, Maryland's Medicaid Managed Care Program.

Health Systems Capacity Indicator #09A - The ability of the state to assure MCH Program access to policy and program relevant information

Maryland's MCH Program has direct access to several surveys and registries that yield rich information about the state's maternal and child health population. These include the state's hospital discharge records, an annual birth defects surveillance system, the BRFSS Survey and the PRAMS Survey. Birth and death records are linked by the Vital Statistics Administration and results are published in three year cohorts, the most recent covering the period 1999-2001. The Title V Program now has direct access to vital statistics files, including linked birth and death files for data analysis.

Newborn screening and birth record files have been linked and Medicaid and birth record files are linked periodically. WIC and birth record files are currently not linked due to U.S. Department of Agriculture and HIPAA concerns.

The Family Health Administration has identified data resource development including data sharing and linkages as one of its key priorities. A new Office of Health Policy was created in FY 2005 to oversee this function. The intent is to strengthen the FHA leadership's collective focus on health outcomes of FHA programs and services and to determine how these health outcomes may be captured by data. FHA is developing a plan for measuring and communicating program outcomes. An inventory of data resources within each Office has been drafted and opportunities for further data collaboration including linkages are being explored.

Health Systems Capacity Indicator # 09A -- The percent of adolescents in Grade 9 through 12 who reported using tobacco products in the past month.

Maryland used funds received from the tobacco settlement to establish the legislatively mandated Tobacco Use Prevention and Cessation Program. The Program was required to collect baseline data on tobacco use habits among youth (middle and high school students) and adults at the state and local levels. These surveys were to be repeated at least every other year for use in monitoring achievement of program goals. Baseline data for the Maryland Youth Tobacco Survey was collected in the fall of 2000. A second survey was completed in the fall of 2002. The surveys show that tobacco use by youth attending public high schools declined from 23% in the fall of 2000 to 17.6% in the fall of 2002. State budget cuts delayed completion of the next round of surveys until 2006.

The Maryland Adolescent Survey (MAS) is jointly sponsored by the State Departments Education; and Health and Mental Hygiene. Every two years, a sample of sixth, eighth, tenths and twelfth graders are surveyed to determine trends the use of alcohol, tobacco, and other drugs among adolescents. The most recent survey results for 2002 was completed by 33,979 students and represented 12 to 14% of the state's school enrollment. Reported findings included reductions in thirty day tobacco use rates for tenth and twelfth graders. Data from the 2004 survey will soon be available.

Maryland become a YRBS state 2004. Students completed the first survey in April 2005 and the state is currently awaiting CDC approval of the state's sample. If acceptable to the CDC, survey findings are expected to be available by next summer.

Health Systems Capacity Indicator #09C -- The ability of the state to determine the percent of children who are obese or overweight.

There is currently no database or surveillance system in Maryland that allows for the annual tracking and monitoring of obesity rates among children. However, several efforts to improve surveillance are currently underway. For example, legislation passed in 2004 requires the state to begin participation in the YRBS surveillance system. This will eventually provide data on the obesity/overweight status of adolescents. On a periodic basis, both the WIC and Medicaid Programs has agreed to share data on

the Body Mass Index of enrolled children with program staff in the Family Health Administration, including MCH. The BRFSS Survey has added questions that will allow the state to determine the prevalence of overweight and obesity among children and adolescents in BRFSS households. In addition, Maryland is currently reviewing BMI prevalence data provided by the National Survey of Children's Health.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

This section describes Maryland's progress on required national and state performance measures and documents accomplishments, current activities and the state's plan for FY 2006. In many cases, the most current available data is for calendar (CY) or state fiscal year (FY) 2003. Therefore, for many performance measures, we were unable to report on progress for FY 2004. In several instances, the data for the year 2004 will not be available until the fall of 2005 or later. As this data become available, it will incorporated into subsequent applications.

In FY 2004, Maryland's Title V Program served approximately 210,000 pregnant women, infants, children, including those with special health care needs and adults. As this report will show, Maryland was able to meet or surpass many of its target objectives for the state's 33 performance and outcome measures. For example, the following positive outcomes were observed:

NPM #7 -- Immunizations: There was almost a 3 percentage point increase in the percent of children immunized.
NPM #8 -- Teen Pregnancy: The rate declined for the tenth straight year.
NPM #11- Breastfeeding: The percentage of women breastfeeding at hospital discharge continued a slow, but steady increase.

Conversely, the following measures are cause for concern because they did not show improvement:

NPM #18 - Early prenatal care: Early prenatal care rates in the state continued to declined from 88% in 1997 to 83.7% in 2003.
OM #1 -- Infant Mortality: While there has been a 8.6% decrease in the state's infant mortality rate over the past 10 years, the infant mortality rate increased between 2002 and 2003.

Maryland's MCH Program seeks to improve and enhance the health of all Maryland women, infants, and children including those with special health care needs through funding of Title V and state supported activities and programs. The Program's vision includes a State in which: all pregnancies are planned, all babies are born healthy, all children including those with special needs reach an optimal level of health, and all women and children have access to quality health care services. Title V activities discussed in this document are designed to reflect this vision.

Activities and services are delivered at each level of the MCH pyramid and directed at each of the Title V population groups: pregnant women and infants, children and adolescents, and children with special health care needs. Reducing infant and child mortality and improving health outcomes are Program priorities as described in the next section. All activities and programs are linked to these outcome measures.

B. STATE PRIORITIES

Below are Maryland's 8 priority needs identified, as required, as part of the state's 2005 Needs Assessment process. Please note that while the 2005 priorities are numbered, the assigned numbers do not reflect their importance. Consideration was given to multiple factors in selecting Maryland's 2005 MCH priority needs. These included findings from a review of data trends and analyses; focus group comments; local health department surveys and meetings; the CAST -- 5 capacity assessment and input from Title V Program staff and other MCH serving agency staff in DHMH.

1. To eliminate racial and ethnic disparities in maternal and child health.

Over the past two decades following the publication of national and state reports (e.g., the 1987 Maryland Governor's Commission on Black and Minority Health), awareness has been raised about racial and ethnic disparities in health. Both the Maryland Department of Health and Mental Hygiene and the Title V Program are committed to eliminating health disparities. DHMH was also recently

mandated by the state Legislature to create an Office of Minority Health and Health Disparities. Racial and ethnic disparities were identified as a priority area during the last comprehensive needs assessment remain as a priority for the 2005 needs assessment.

Maryland data consistently reveal substantial racial and ethnic disparities on numerous key indicators of heath and access to health care including infant and child mortality. The research literature is increasingly recognizing that social factors including poverty, and discrimination contribute significantly to these disparities. Maryland has begun to look at the role of stress and racism as a stressor in poor birth outcomes for African American babies. The role of public health in addressing social issues that normally have been viewed as issues that fall outside of our rubric will be considered over the next five years as Maryland attempts to address persistent, yet amenable disparities within its maternal and child health population. Technical assistance will be provided to local health departments and other MCH serving agencies within DHMH to address this priority.

The selected state performance is the percentage of jurisdictions with written plans to address racial/ethnic disparities in MCH. A related national outcome measure is the ratio of Black infant deaths to white infant deaths. A concerted effort will be undertaken to determine the causative factors of key disparities, including maternal and infant mortality, and asthma morbidity.

2. To promote healthy pregnancies and healthy pregnancy outcomes.

As part of its mission statement, Maryland's Title V Program envisions a future in which all pregnancies are planned, all women reach an optimal level of health and well-being prior to pregnancy, no woman dies or is harmed as a result of being pregnant, and all babies are born healthy. Results of the 2005 Needs Assessment indicate that much work remains to be done if this future is to be realized for all mothers and babies. The majority of babies in our state are born healthy to healthy mothers who experience healthy pregnancies. However, Maryland continues to have one of the nation's highest infant mortality and low birth weight rates. The health disparities identified in priority #1 partially contribute to this finding.

Two state performance measures have been selected to address this priority: (1) Percentage of pregnancies intended, and (2) Percentage of women using alcohol during pregnancy. This priority is directly linked to the infant mortality outcome measure as well as performance measures # 8, 15, 17 and 18.

3. To promote optimal family functioning.

Throughout the five year needs assessment, we heard about the need to support and strengthen families to assure that children remain healthy and thrive. This need for support is cross-cutting and required for all Maryland families, especially socio-economically disadvantaged families. However, the Title V Program also recognizes that families of children with special health care needs are especially vulnerable and in need of services that enhance their ability to care for their children and address their need for supportive services such as respite and child care.

Many Maryland families were anecdotally described as "in crisis or in peril." We heard that families are disconnected; parents are stressed and overwhelmed with the process of parenting as well as accomplishing the tasks of daily living; parents are placing demands on their children to be "successful;" children are being abused and neglected; and parental substance use is a growing problem. Family support can take many forms including parenting classes; affordable quality child care; mental health counseling programs; and substance abuse treatment programs. Over the next five years, the Title V Program will promote optimal family functioning by partnering with other MCH serving agencies, families, and communities to develop and implement policies and programs that promote optimal family functioning for all families.

4. To promote healthy children.

Similar to 2000 needs assessment findings, both qualitative and quantitative data continued to reveal unacceptable levels of morbidity and mortality among children in the early and middle childhood periods. Areas of continuing concern included asthma, overweight and obesity, dental caries, mental health related problems, and child abuse and neglect. This priority was selected to ensure continued focus on improving the health of children in the early and middle years. For example, asthma currently affects more than 100,000 Maryland children and it is the leading cause of hospitalization for children in the elementary and middle school years as well as leading reason for school absenteeism. Asthma is a controllable disease when properly managed. The use of hospital emergency departments for routine asthma management can be an indicator of poor asthma management. The Maryland Asthma Control Program which is administratively housed in the Center for Maternal and Child Health is implementing a statewide plan to reduce mortality and morbidity from asthma by promoting educational and other to improve asthma management. The emergency department use rate due to asthma will be used as one the state performance measures for this priority.

This priority was also chosen because of the relationship between health, school readiness and school performance. The Center for Maternal and Child Health is the recipient of an MCHB funded Early Childhood Comprehensive Systems Grant. This funding is being used to develop a plan for promoting school readiness by improving the health of young children in Maryland through early childhood systems building and collaboration. The second state performance measure for this priority is the percentage of students entering school ready to learn.

5. To promote healthy adolescents and young adults.

Adolescence, however it's defined (ages 10 -- 19 or 12-19 or 13-24), is a time of tremendous change and growth. This transitional developmental period between childhood and adulthood offers many physical, mental and emotional challenges. Risk taking is the norm during this period. Many adolescents make the transition to adulthood with few problems, others do not fare as well. Focus groups with parents and service providers consistently identified the need to promote healthy, positive youth development by offering adolescents "a sense of future." The health care system was not viewed as "adolescent friendly" and seen as ill equipped to address growing mental health, psycho-social and emotional problems of teens. Hence, adolescent health promotion was chosen as a priority to highlight the unique needs and issues that affect this often overlooked segment of the MCH population within the public health system.

Data on the health and mental health of Maryland adolescents, beyond traditional vital statistics measures, is limited. The Title V Program has chosen the high school graduation rate as the state performance measure and the adolescent/young adult mortality rate as an outcome measure for this priority. Other national Title V measures linked to this priority include rates of teen births, suicide, juvenile arrests and high school drop-outs.

6. To promote healthy nutrition and physical activity across the lifespan.

Adult and childhood overweight/obesity is increasing at alarming rates in the U.S. and we suspect in Maryland. Data on the prevalence and incidence of childhood overweight is currently limited, but efforts are underway to improve obesity surveillance in Maryland. The latest BRFSS data for adults indicates that almost half were overweight or obese and that these rates have increased over the past decades. Rising rates of childhood overweight and obesity were repeatedly identified as a concern by focus group participants, service providers and local health department staff. Two major factors accounting for the rise obesity rates include unhealthy eating habits and physical inactivity. Parents in our focus groups expressed concerns about school vending machines that promote unhealthy eating habits, a decline in physical education programs and outdoor recess time in schools, and an increased reliance on sedentary activities such as television viewing and computers for entertainment. Because Maryland currently does not have an obesity/overweight surveillance system for the entire child population, a performance measure will be developed in the interim years as data capabilities in this area improve.

Breastfeeding is recognized as the optimum form of nutrition for infants throughout the first year of life. While breastfeeding initiation rates in Maryland have been improving and are approaching the Healthy People 2010 goal of 75%, few Maryland moms continue to breastfeed beyond the early months. Survey data for 2003 estimate that at six months, two in five mothers continued to breastfeed and less than one in five breastfed exclusively. Because breastfeeding has long term benefits and is viewed as essential to giving infants an optimal nutritional start in life, Maryland has chosen the percentage of infants breastfeed at six months as the state performance measure.

7. To improve systems of care for Children with Special Health Care Needs

A problem highlighted in the needs assessment by both families and providers is the issue of "navigating the system" or finding out about available services within the community and gaining access to them. This is particularly troublesome for CSHCN and their families who require not only extensive health care services but also multiple family support services. The OGCSHCN has addressed this by funding information and referral mechanisms at the large specialty centers, at a Regional Resource Center on the Eastern Shore, and at Parents' Place of Maryland. However, the majority of these centers are located centrally within the state, and getting the word out has been slow. Not all local jurisdictions are equipped to assist families with locating needed services, and parents do not feel that that pediatrician's offices are a good source of information on accessing community resources. Pediatricians agree that they don't typically have this type of information. There is a need to improve the capacity of local jurisdictions and a child's medical home to quickly and efficiently disseminate information about community resources and to advertise the information and referral mechanisms that already exist. The selected state performance measure for this priority is the percentage of jurisdictions that partner with medical homes to develop and disseminate resource materials.

8. Improve the infrastructure for supporting systems of care for women, children and families

This broad priority focuses on infrastructure level issues, namely data, work force and manpower maldistribution issues that impact the state's ability to serve mothers and children. The CAST- 5 process noted that Maryland's Title V Program has recently made substantial process in collecting and analyzing data since the last needs assessment. CMCH now employs both a senior level MCH epidemiologist and a family planning program epidemiologist. The PRAMS data set is now available and YRBS data may be available as early as next summer. However, it was noted that current capacity remains insufficient for undertaking in-depth studies that could provide greater direction for development of MCH policies and interventions. For example, in the mid-nineties, Maryland had one of the nation's highest early prenatal care rates, but over the past several years, early prenatal care rates have declined significantly. The Program lacks sufficient capacity to fully examine the reasons for this decline. In this instance, staff had the expertise, but lacked the time to perform this in-depth analysis.

The CAST-5 discussions also revealed that the CMCH process for data analysis is not systematic and that greater understanding of the needs affecting the most vulnerable MCH populations in our state is the goal, then the environment for data sharing will need to be improved, in addition to work force development. The Title V Program plans to address these issues by identifying at least one major issue requiring in-depth study and analysis each program year. This work will be accomplished in partnership with other MCH serving agencies, where appropriate. The initial state performance measure for this priority will be the number of policy briefs developed.

Public health work force and health manpower shortage and development issues were identified as a subset for this priority. A great deal of concern was expressed throughout the CAST-5 deliberations and in meetings with local health departments about the long term implications of several public health MCH workforce issues.

Several needs identified through the current assessment related to the availability and maldistribution of health resources, particularly for oral health, mental health and primary health care services.

Solutions to the problems of manpower shortages will be considered and discussed in subsequent annual applications.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	95	95	95	95	95
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	117	125	135	154	132
Denominator	117	125	135	154	132
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	95	95	95

Notes - 2002

Newborn screening data is reported on the Calendar Year.

Notes - 2003

Newborn screening data is reported by calendar year, CY 2003, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

Notes - 2004

Newborn screening data is reported by calendar year, CY 2004, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

A new performance objective is not formulated. We are not sure if we can sustain our historical strength in this area because of the problems of obtaining data from the commercial laboratory. They do not report all abnormals, only presumptive positives, and they do not report data on all babies, only those born in Maryland hospitals with whom they have a contract. For example, they will not report abnormals, even presumptive positives on home births. While we continue to work with them to improve the situation, we are concerned that the chance for us to miss a baby or lose one between the cracks has increased.

a. Last Year's Accomplishments

Maryland continued its historical strength in providing a comprehensive program of state-sponsored services for genetic disorders. Close to 100% of newborns received newborn screening and the OGCSHCN provided the necessary short-term follow-up for all infants with abnormal metabolic screens. No confirmed cases were lost to follow up, but one infant

suspected of having sickle cell disease was lost to follow up. The OGSHCN continued to work closely with the major genetics specialty centers in the area to ensure that all babies needing a diagnostic evaluation received this, and that all children with confirmed disorders and their family members received the appropriate genetic services. In addition, the OGCSHCN provided longer-term follow-up services including case management, nutritional management, counseling, health education, and family support to 305 families with confirmed metabolic disorders in FY 04 and 1,446 children with sickle cell disease. In FY 2004, the genetics centers served over 7,361 individuals.

Maryland fully implemented tandem mass spectrometry for the detection of disorders of the urea cycle, fatty acid oxidation, and organic acid metabolism and began expanded newborn screening for 32 disorders in November 2003. FY 2004 was spent in refining cut offs and reducing false positives as well as refining our follow up protocols and patient and professional educational materials. Indeed these efforts continue through the present. Pediatrix (formerly NeoGen) became licensed to do first tier newborn screening in the State in 2003. Although Pediatrix provided screening for only a small proportion of the hospitals in the State at the beginning of CY 2004 (5 out of 35 birthing hospitals), by the end of CY 2004 Pediatrix had contracts with 11 0f 35 birthing hospitals. These include some of the larger birthing hospitals and by the end of CY 2004, Pediatrix was positioned to screen approximately a third of Maryland births. The OGCSHCN continues to work with Pediatrix as well as the State Public Health Laboratory to do the short and long term follow up for all Maryland babies with abnormal screening test results. However, there have been significant challenges to the comprehensive system of follow-up existing in Maryland following the introduction of a commercial laboratory.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support newborn screening for 32 disorders for all Maryland babies			X	
2. Develop a newborn screening protocol for cystic fibrosis and add to panel			X	
3. Provide short-term follow up assuring that all abnormal or inadequate results are followed to resolution	X	X	X	
4. Provide parent educational materials, including a video and a web site, on newborn screening in Maryland in multiple languages		X	X	
5. Support the State's designated metabolic, endocrine and hematology centers (small grants)				X
6. Provide metabolic nutritionists in the OGCSHCN to provide case management and nutritional therapy	X	X		
7. Provide casemanagement for sickle cell disease patients to age 5	X	X		
8. Provide provider education, including a detailed practitioner's manual for primary care providers		X	X	X
9. Work with commercial newborn screening laboratory to assure complete State data			X	X
10. Enhance the follow up computer system and follow-up database to accommodate data from 2 laboratories (State lab and commercial lab)				X

b. Current Activities

There continue to be significant differences of opinion between Pediatrix and the OGCSHCN as to what data Pediatrix is pledged to exchange with the OGCSHCN, as to what constitutes a

"Maryland baby' and in the interpretation of the relevant portions of HIPAA with regard to information exchange. Pediatrix maintains that they are only required to report babies screened as a result of a contract with a Maryland hospital, that home births have "opted out" of the Maryland system and that military facilities are on federal territory and not "in Maryland". They decided to report abnormal results on military babies because the military physicians, used to the follow up services of the OGCSHCN, insist on it. They also only report presumptive positives, rather than all not normal results. This makes it very difficult for the OGSCHCN to assure that all babies are, in fact, screened and makes it impossible for Maryland to complete the National Newborn Screening and Genetics Resource Center's annual report because that requires all not normal results. The settlement agreement is not detailed enough to settle these issues. The OGCSHCN continues to work with Pediatrix on the issues of data exchange.

The new data system for the laboratory was completed but it seems the laboratory will not use it but will wait for the new standardized newborn screening laboratory module produced by the Association of Public Health Laboratories and the CDC. This module is part of a much larger general nationally standardized public health laboratory data system.

Dr. Terry Davis from LSU came to Maryland last year and moderated several focus groups with providers and parents on the topic of communication efforts around newborn screening. Feedback on Maryland's educational materials related to newborn screening was obtained. Important information about ways to communicate with parents and physicians about newborn screening and the new disorders added to the Maryland panel was also gathered. Print materials for parents and providers were revised. The OGCSHCN web site was revised. Information on the web site is "layered". The initial information is very simple for parents who just want a general idea, but by clicking on links, the viewer can access more and more detailed information. We are in the process of producing a simple video on newborn screening to be shown on hospital health education channels and OB and pediatric offices waiting rooms. The video will be available on our web site. We hope this will assist in obtaining informed consent from parents. These materials will have to be continually refined. Professional education materials are in the process of being posted on the web site.

c. Plan for the Coming Year

In FY 2006, the OGCSHCN will continue to work with Pediatrix to clarify data reporting requirements. The OGCSHCN will work with the new New York /Mid Atlantic Cooperative (NYMAC) on newborn screening issues. Cystic fibrosis will be added to the newborn screening panel. We have begun to work with a multidisciplinary committee to plan for CF screening. Maryland plans to use a double IRT protocol for CF screening to avoid identifying carriers. This is possible because Maryland has a routine second specimen at approximately 2 weeks of age. The proposed protocol will be: 2 positive IRTs, then sweat testing, then referral of the positives to the CF center and then mutational analysis. Genetic counseling will be provided and long term care coordination and outcome data collection will occur at the CF center. Parent and professional educational materials are being produced. We will set up and assure the quality of sweat testing at approximately 5-7 medical centers around the state so that no family has to drive for more than approximately one and a half hours to reach such a facility.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			65	70	70
Annual Indicator			68.1	68.1	68.1
Numerator			142329	142329	142329
Denominator			209000	209000	209000
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	75	75	75	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

According to the National Survey of CSHCN, over 68% of Maryland families of CYSHCN report that they are partners in decision-making and are satisfied with the services they receive, compared with 57.5% nationally. When the components of this indicator are examined individually, over 88% of families report that their child's health care providers help them feel like a partner in care, and over 70% are satisfied with services. Disparities exist for CYSHCN in Hispanic families, uninsured CYSHCN, and for children who have functional limitations.

The OGCSHCN continued to support Parents' Place of Maryland (PPMD), a non-profit, family-centered organization serving parents of children with disabilities. PPMD also houses the Maryland chapter of Family Voices. The OGCSHCN supports PPMD in its efforts to educate parents/caregivers of CYSHCN about health and related issues and to help them become advocates for their children. This is accomplished through a variety of mechanisms. Last year, PPMD began disseminating information to families with an electronic newsletter. PPMD conducts regular parent education courses and workshops throughout the state on health-related topics. PPMD also provides individual assistance to families on effectively accessing health and related services by telephone, e-mail, and face-to-face meetings. PPMD employs parents of CYSHCN, and has a network of 6 part-time parents representatives throughout the state to work directly with families around health issues. In FY04, PPMD provided direct assistance to 804 families of CYSHCN. PPMD has also been successful in its efforts to increase outreach to ethnic/racial minority families in the past year.

In it effort to promote family-centered care and professional collaboration, the OGCSHCN enables PPMD to provide parent input in health policy and program design activities by supporting participation of its staff in a number of venues such as the Special Needs Children Advisory Council, the Medicaid Advisory Committee, and local committees in a number of counties. The OGCSHCN also employs 2 parents of children with special health care needs.

One heads the Birth Defects Reporting and Information System and provides information and referrals to the parents of babies with birth defects. The second is our Regional Resource Coordinator. She has been particularly active and effective in lending her expertise as a parent to the Maryland Developmental Disabilities Council, the Governor's Caregiver Support Coordinating Council, and the Taskforce on Inclusive Child and After-School Care, among other activities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support Parents' Place of Maryland to help parents of CYSHCN become better advocates for their children through education and training.		X		X
2. Support Parents' Place of Maryland to provide direct assistance to families of CYSHCN in accessing health and related services.		X		
3. Support employment of family members of CYSHCN.		X		X
4. Support parent input into health policy and program design activities.				X
5. Support needs assessments and training for disease-specific parent organizations like the Chesapeake-Potomac Spina Bifida Association.				X
6. Collaborate with stakeholders around outreach and enrollment of families into vountary confidential database of CYSHCN.			X	X
7. Support Parents' Place of Maryland to implement Maryland LEADers training program.				X
8. Partner with Parents' Place of Maryland to convene a Medical Home Work Group in Maryland.				X
9. Develop and conduct a survey of participants in the voluntary confidential database of CYSHCN.				X
10. Support Parents' Place of Maryland in its efforts to increase outreach to providers.		X		X

b. Current Activities

The OGCSHCN continues to work with PPMD on a voluntary, confidential database of CYSHCN in Maryland. This database includes identifying information, demographics, information about diagnosis, health insurance data, and types of services received and needed. Consent is obtained to contact the families periodically to gather more detailed information for needs assessment purposes and to give families of CYSHCN throughout the state the opportunity to have a voice in program and policy decisions to the extent possible. The database is housed and operated by PPMD. PPMD is collaborating with partners such as the Maryland chapter of the American Academy of Pediatrics (AAP), the Centers of Excellence, and parent groups to identify strategies for enrolling families of CYSHCN in the database. Special outreach efforts are being made to collect information from subgroups such as ethnic/racial minorities. There are currently between 350-400 families enrolled in the database.

PPMD is in the final stages of the development and planning of a specialized training course for family members of CYSHCN, the Maryland LEADers Training Program, to assist them in taking their advocacy and leadership skills to a higher level. Topics for this training will be based on the 6 MCHB core elements and the President's New Freedom Initiative. Criteria for selection into the program's 20 slots will focus on geographic, racial/ethnic, and economic diversity of participants. The program will run from September 2005 through May 2006.

PPMD is a partner with the OGCSHCN in convening a Medical Home Work Group in the state, discussed in more detail under NPM #3. PPMD is providing parent leadership and staff support for this group, supported by an incentive award from the Champions for Progress Center. A number of parents are active participants in the ongoing work of this group.

c. Plan for the Coming Year

In the coming year, we hope to increase participation in the CYSHCN database and to start examining the existing data in detail. We also plan to support PPMD to develop and conduct the first survey of participants, content to be determined. There are certainly a number of issues identified in this year's needs assessment for which we might want to pursue additional data.

In the coming year, PPMD parent representatives will be working to increase outreach to pediatricians in their communities and expand their relationship with these providers. Pediatricians should be aware of PPMD as an important resource for their families of CYSHCN. PPMD will be working with the Maryland chapter of the AAP and the OGCSHCN in this effort. PPMD has already established a plan with the primary care clinic at the University of Maryland to develop a video for their waiting area and also to examine the utility of having a parent representative available on-site once per month.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			55	60	60
Annual Indicator			56.3	56.3	56.3
Numerator			117667	117667	117667
Denominator			209000	209000	209000
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	65	65	65	65

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

According to the 2001 National Survey of CSHCN, just over 56% of Maryland CYSHCN are receiving care that meets criteria for a medical home, compared with 52.7% nationally. Although the more recent 2003 National Survey of Children's Health measured medical home in a different fashion, similar results were seen for Maryland with over 51% of CYSHCN reporting care consistent with a medical home model.

The OGCSHCN provided input into medical home focus groups with parents and providers that were conducted by the Maryland chapter of the American Academy of Pediatrics (AAP) this past year. The OGCSHCN reviewed the focus group data and other available Maryland data related to medical home as a part of the needs assessment process. Strengths included CYSHCN having a usual source of care and care that is family-centered. Gaps were found in care coordination, and in obtaining referrals when needed. Time and reimbursement issues were the greatest barriers to providing medical homes from a provider perspective.

Last year the OGCSHCN continued to work with families who are identified and receive services through its programs to find a medical home to the extent possible. This includes children and their families who are identified through the Newborn Metabolic Screening Program, Universal Newborn Hearing Screening Program, and Birth Defects Reporting and Information System, as well as children served in the Children's Medical Services specialty care payment program. The OGCSHCN continued to support the Complex Referral Clinic at Children's National Medical Center which functions as the medical home for some of the children it serves. In its second year, FY 04, there were 140 visits to this clinic for 50 patients.

The OGCSHCN gives monies to a number of local health departments to support care coordination activities. In FY04, care coordination was provided to 852 CYSHCN. We had hoped for a care coordination model in some counties that would better support local pediatric health care providers' ability to provide a medical home for their patients with special health care needs; however, the health department staff has experienced some difficulty in establishing working relationships with the physicians.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with families receiving services through the OGCSHCN to find medical homes.		X		
2. Support Complex Referral Clinic, which serves as the medical home for some Maryland children with complex conditions.				X
3. Support medical home providers by direct provision of case management services for CYSHCN in some OGCSHCN programs and by funding care coordination in local health departments.		X		X
4. Participate in medical home needs assessment activities with the Maryland chapter of the AAP.				X
5. Partner with Parents' Place of Maryland to convene a Medical Home Work Group in Maryland.				X
6. Participate in the Medical Home Learning Collaborative II.				X
7. Support inclusion of medical home topics in annual CME activitiy for				X

pediatricians sponsored by Children's National Medical Center.				
8. Start dialogue with Maryland Medicaid about reimbursement issues impacting provision of medical homes to CYSHCN.				X
9. Participate in NYMAC work group on ensuring medical homes for children with diseases identified through newborn screening.				X
10.				

b. Current Activities

The OGCSHCN applied for and received an incentive award from the Champions for Progress Center to convene a Medical Home Work Group in partnership with Parents' Place of Maryland. This work group brings together important state and local medical home stakeholders to educate them about medical home concepts, to develop Maryland specific medical home materials targeted at families and health care providers, and to create a State plan for addressing the 2010 medical home objective for CYSHCN. This group has been meeting on a regular basis since February 2005 and work is ongoing.

The OGCSHCN is supporting Maryland's participation in the Medical Home Learning Collaborative II sponsored by NICHQ. This project seeks to promote medical homes for CYSHCN using quality improvement methodology within primary care practices. State partners are the Maryland chapter of the AAP and Parents' Place of Maryland. Two OGCSHCN staff members, a physician and a nurse, are active members of the State team. Maryland has one primary care practice team, Dundalk Pediatric Associates, involved in the collaborative.

With grant support from the OGCSHCN, Children's National Medical Center is devoting a portion of its annual Future of Pediatrics full day CME program for pediatricians to medical home topics including "How to Make Your Practice a Better Medical Home," "Managing the Medically Complex Child," and "Improving CPT Coding for Care Coordination." The program is scheduled for June 2005.

c. Plan for the Coming Year

The OGCSHCN will continue its involvement in the activities described above that support medical homes for CYSHCN in Maryland. The Maryland chapter of the AAP plans to conduct a survey of parents and providers in the coming year to validate the data collected in the medical home focus groups. The OGCSHCN will again provide input into this process. The OGCSHCN plans to work more closely with the local health departments involved in care coordination to strategize about how they can use their services to support primary care practitioners in their ability to provide a medical home to their patients with special health care needs and their families.

The OGCSHCN also hopes to build upon the efforts of the Medical Home Work Group and Medical Home Learning Collaborative II to expand medical home awareness and activities within the state. For instance, we recently invited staff from the Maryland Medicaid Program to participate in a teleconference on reimbursement strategies supporting the medical home sponsored by the Medical Home Learning Collaborative II, and we now plan to have an ongoing dialogue with Medicaid on this topic. A longer-term goal of the OGCSHCN is to obtain public or private grant funding to support a larger medical home implementation project in Maryland based upon the State plan developed by the Medical Home Work Group.

Lastly, the Associate Medical Director of the OGCSHCN will serve as the Maryland representative on a work group that is being convened by the New York-Mid-Atlantic Consortium for Genetic and Newborn Metabolic Services (NYMAC). The objective of this work group is to develop collaborative partnerships between primary medical care providers, genetic and/or specialty care providers, and health insurers to ensure continuity of medical care within

a medical home for children identified with diseases by newborn screening programs. The first meeting of this work group is scheduled for August 2005.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			65	70	70
Annual Indicator			67.5	67.5	67.5
Numerator			141075	141075	141075
Denominator			209000	209000	209000
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	75	75	75	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

On the 2001 National Survey of CSHCN, over 97% of Maryland families of CYSHCN reported that their child had public or private health insurance at the time of the survey. The national rate of uninsurance was almost double the Maryland rate. The overall high rate of insurance coverage for Maryland CYSHCN is supported by more recent data from the 2003 National Survey of Children's Health, where almost 96% of CYSHCN were insured at the time of the survey. Adequacy of insurance is the greater challenge, with estimates that almost 1/3 of Maryland CYSHCN do not have insurance that is adequate to pay for the services they need based on the 2001 National Survey of CSHCN. Disparities exist in both health insurance access and adequacy. The needs assessment highlighted a number of factors potentially contributing to inadequacy including high out-of-pocket costs, limited access to needed providers, and complexity of using health plans.

The OGCSHCN continued to provide payment for specialty care and related services through the Children's Medical Services Program (CMS) to Maryland CYSHCN who were uninsured or

underinsured and had family incomes up to 200% FPL. In FY04, CMS served about 135 children, the vast majority of whom were unable to obtain health insurance coverage due to their citizenship status. The OGCSHCN continued to refer potentially eligible families to medical assistance and MCHP as well as other public programs that might provide pathways to securing funding for health care and related services such as SSI and DDA. For those who are not eligible for these programs nor CMS, the OGCSHCN makes every effort to connect the family with other privately funded sources of care and resources, such as Catholic Charities.

The OGCSHCN is nearing the completion of HIPAA-compliant electronic claims payment system for the CMS Program. This project was required by the Maryland Department of Health and Mental Hygiene for all of its units that process patient claims. While this project has taken considerably more time and effort than anticipated, it will allow the CMS Program to more efficiently handle payment of claims for children receivng services in the CMS Program. The new system will also provide us with more ready access to important CMS Program data.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide payment for specialty care and related services to CYSHCN who are uninsured or underinsured with family incomes up to 200% FPL.	X			
2. Refer potentially eligible families to MA, MCHP, and other public and private programs that may provide funding for health care.		X		
3. Support Parents' Place of Maryland to educate parents of CYSHCN about health insurance and how to access services for their children through a series of workshops.		X		
4. Support parent input into health policy and program design activities related to health insurance for CYSHCN.				X
5. Implement changes to CMS Program regulations which will allow the program to serve more CYSHCN.				X
6. Collaborate with local jurisdictions to facilitate enrollment of CYSHCN without health insurance into CMS Program.		X		X
7. Support Parents' Place of Maryland to disseminate data from focus groups on insurance issues for CYSHCN.				X
8. Start dialogue with Maryland Medicaid about reimbursement issues impacting provision of medical homes to CYSHCN.				X
9.				
10.				

b. Current Activities

In response to cuts to the Medicaid program in the Governor's FY06 budget, Maryland Medicaid proposed to eliminate the Rare and Expensive Case Management Program (REM) which was established as a carve-out of HealthChoice (Medicaid managed care) in 1997. REM primarily targeted children with chronic, severe health conditions such as cystic fibrosis, spina bifida, and HIV/AIDS. The program benefits included fee-for-service Medicaid, intensive case management, and access to specialty care without a referral. The program served nearly 3000 children. Under the proposal, REM enrollees would be transitioned to managed care organizations and lose the REM benefits. Advocates for CYSHCN were strongly opposed to the elimination of REM, and legislation was introduced during the 2005 legislative session to

protect it. Although no action was taken on the bills, budget language was passed that allowed REM to continue for another year. However, a report must be developed in consultation with stakeholders that includes the development of cost containment strategies and the consideration of alternatives to the program. Staff from the OGCSHCN are participating in a series of meetings over the coming months that have been set up to elicit stakeholder input.

The OGCSHCN continues to support Parents' Place of Maryland (PPMD) in its efforts to increase the knowledge and skills of parents/caregivers of CYSHCN so that they may more effectively access health care services for their children. PPMD developed five workshops for families related to insurance issues including "Choosing the Right Plan for Your Child with Special Health Care Needs," "Getting What Your Child Needs from Your Managed Health Care Plan," and "Strategies for Appealing Your Health Plan's Decision." PPMD began holding these workshops in early FY05, and by December 2004 had conducted 6 workshops in 5 counties with 64 participants, mostly parents. These workshops are now scheduled on an ongoing basis throughout the state.

The OGCSHCN supports PPMD staff to provide parent input in health policy and program design activities. The Maryland Special Needs Children Advisory Council for Medicaid (SNCAC) is co-chaired by the Executive Director of PPMD. Staff from the OGCSHCN also sit on this advisory council. SNCAC continues to examine issues of importance related to CYSHCN and to make recommendations to Medicaid. Recent work of the council has focused on the issues with REM as discussed above. PPMD members are also participating in a subcommittee to develop parent-friendly materials for parents who have CYSHCN in Maryland Medicaid programs. In addition, PPMD family representatives meet with the Special Needs Coordinators from each HealthChoice MCO at least quarterly to share information and resources regarding CYSHCN. Information is also disseminated to the REM case managers regarding CYSHCN at least twice per year.

c. Plan for the Coming Year

Over the past year, the OGCSHCN has been exploring mechanisms for more efficiently operating the CMS Program due to its decreasing enrollment over time and failed attempts in the past to expand eligibility and/or services. We considered moving a significant portion of CMS into the community, but it was not clear from our investigation that this was the best course of action to take for the program. While considering our options, we have been given approval to update our regulations to automatically include the most recent federal poverty guidelines; our current regulations are still using the FPL from 1999. We hope that this will allow us to serve more CYSHCN in the program. We also hope to institute a yearly cap on dollars spent per individual child in the program in order to spread the monies out over a greater number of children.

The decision to institute these changes to our regulations has proven to be timely. The Governor's FY06 budget eliminates as of July 1, 2005 a $7 million Medicaid program for low-income pregnant women and children who are legal permanent residents of Maryland but who have not lived in the US for a minimum of 5 years. This cut will leave about 3,000 Maryland children without health insurance. The OGCSHCN is in contact with local jurisdictions, patricularly those with the highest numbers of children who will lose their insurance, to facilitate the enrollment of potentially eligible children into the CMS Program. While it is unclear at this time what the impact on the CMS Program will be, based on current prevalence estimates of CYSHCN in Maryland, this could mean up to an additional 450 children potentially becoming eligible for CMS Program coverage of specialty care and other services related to chronic conditions. This is greater than 3 times the number of children currently served, and may significantly strain the current program resources.

With support from the OGCSHCN, PPMD has recently completed a series of focus groups on insurance issues with families of CYSHCN, in particular focusing on differences in adequacy of insurance for CYSHCN who are publicly insured versus those who have private insurance. Data is in the process of being compiled, and PPMD plans to widely disseminate the report of the focus group findings.

Lastly, related to our medical home activities, we plan to start a dialogue with Medicaid staff regarding coding and reimbursement strategies to support medical homes for CYSHCN.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			70	75	75
Annual Indicator			70.6	70.6	70.6
Numerator			147554	147554	147554
Denominator			209000	209000	209000
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	80	80	80

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

On the 2001 National Survey of CSHCN, over 70% of Maryland families of CYSHCN reported that community-based services were usually or always organized for easy use. The needs assessment highlighted disparities in report of services being organized for easy use as well as key problems in the areas of "navigating the system" and local availability and access to a variety of services.

An ongoing concern for families is the limited availability of pediatric specialists, dentists, and specialized therapy services such as PT, OT and speech in the outlying areas of the state.

Even when providers are available locally, there may be other access barriers such as long waiting lists or insurance issues. Over the past year, the OGCSHCN continued to support the infrastructure for selected outreach specialty clinics throughout the state to the extent possible. In addition, the OGCSHCN continued to support wrap-around services at the major tertiary care centers for Maryland children (Centers of Excellence). In FY04, there were over 1750 visits made to 24 outreach specialty clinics serving CYSHCN, and over 94,000 visits made to specialty clinics at 3 Centers of Excellence.

The OGCSHCN has continued to focus effort on assisting families with "navigating the system." The OGCSHCN awards grants to four Centers of Excellence in Maryland and Washington, D.C. to support a Resource Liaison at each center whose function is to assist families with CYSHCN to find needed resources both within the centers and within their community. In some centers, these individuals may also assist with activities such as the coordination of multiple appointments for the child/family. A grant from the OGCSHCN continued to fund operation of the Regional Resource Center for Children with Special Needs in Wicomico County on Maryland's Eastern Shore. This center, located in the Wicomico County Free Library, staffs a Resource Coordinator for information and referral. It houses accessible computers for child and family use as well as books and audio/videotapes on a variety of special needs topics. In the past year, the OGCSHCN also continued to provide funding to Parents' Place of Maryland to support its information and referral line as well as its network of parent representatives throughout the state who are available to work one-on-one with families of CYSHCN.

The availability of quality childcare and respite services for CYSHCN within their communities remains a significant problem in Maryland. The OGCSHCN continued to support the operation of two medical day care centers that served 79 medically fragile infants and young children in FY04. These centers provide quality childcare, nursing, and developmental services to children whose medical needs are too great to be served in traditional day care settings, allowing their caregivers to return to work. Also continued were grants to local health departments for the funding of a variety of respite services for 797 children in FY04.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support specialty clinic infrastructure, both at the specialty centers and at outreach sites throughout the state.	X			X
2. Support a Resource Liaison at 4 Centers of Excellence, Regional Resource Center on the Eastern Shore, and Parents' Place of Maryland for outreach, information, and referral to families and providers.		X		X
3. Support the operation of 2 medical day care centers serving medically fragile infants and young children.		X		X
4. Support the local health departments to provide enabling services such as respite and care coordination to families within the community.		X		X
5. Support Parents' Place of Maryland to make comprehensive resource database for CYSHCN accessible on the internet.		X		
6. Fund medical day care center to develop a training curriculum for child care providers on inclusion of CSHCN and provide ongoing consultation.				X
7. Participate in Task Force on Inclusive Child and After School Care.				X

8. Work with the Maryland Early Intervention Program to monitor and assure quality of Early Intervention services for families in their communities.				X
9. Work with local health departments, the Maryland chapter of the AAP, and Parents' Place of Maryland to assist pediatricians with providing resource information related to CYSHCN in their offices.		X		X
10.				

b. Current Activities

The OGCSHCN is working with Parents' Place of Maryland to put a comprehensive, searchable resource database on its website to assist families with CYSHCN in finding and accessing needed services. Although the database is complete and up-to-date, there have been some challenges in getting it posted to the web.

The OGCSHCN has been exploring the feasibility of moving a significant portion of the Children's Medical Services Program which serves as the payer of last resort for specialty care and related services for uninsured and underinsured CYSHCN into the community. It is not clear from our investigation that this is the best course of action to take for the program, and recent cuts to Medicaid eligibility for legal permanent residents may complicate the matter further. We are still considering our options.

The OGCSHCN was able to give some additional funding support to one of the medical day care centers to develop a training curriculum for child care providers focused on inclusion of CSHCN in typical child care settings. A day long workshop was held in April 2005 using this curriculum and was very well received. The workshop will be repeated this summer. In addition, the funds support the ongoing availability of professional staff at the medical day care center to provide consultation to child care providers throughout the state related to specific needs for integrating CSHCN into their child care setting.

An OGCSHCN staff person has been participating in the Task Force on Inclusive Child and After-School Care created in FY05 by the Maryland Department of Disabilities. This group sponsored a series of town meetings throughout the state and has subsequently been working on formal recommendations for the Governor regarding inclusive child and after-school care.

The OGCSHCN works with the Maryland Early Intervention Program to monitor and assure the quality of Early Intervention Services for families in their communities. The OGCSHCN also distributes the federal match for the Medicaid eligible children receiving Early Intervention case management. This was 4510 children in FY04.

c. Plan for the Coming Year

The OGCSHCN will continue to support the activities described above in the coming year. In addition, the OGCSHCN was able to increase its support of enabling and infrastructure building services in a number of local jurisdictions for FY06, particularly in the area of care coordination for CYSHCN.

Lastly, needs assessment data showed that pediatrician's offices are typically not a good source of information on community resources. The OGCSHCN plans to work with the local health departments, the Maryland chapter of the American Academy of Pediatrics, and Parents' Place of Maryland to develop a strategy for reaching out to pediatric practices and assisting them with making this type of information available to families in their office setting using a variety of different mechanisms.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			5	10	10
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	15	15	15

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The 2001 National Survey of CSHCN estimates that the number of Maryland CYSHCN ages 13-17 who receive the services necessary to make the transition to all aspects of adult life is only 2.7%; this is compared with an estimate of 5.8% for the nation as a whole. Closer evaluation of available transition data indicates that some of the important components necessary for successful transition are occurring for some Maryland CYSHCN; however, for the majority of CYSHCN it appears that there is no comprehensive plan to assist with transition to adult life.

Because there has been an attempt in Maryland to address the non-medical aspects of transition through the Maryland Interagency Transition Council, the OGCSHCN felt that there was a greater need to focus on health care transition. Multiple focus groups on health care transition were held throughout Maryland this past year with parents and YSHCN in order to determine the areas of need. These focus groups provided us with some important insights into the priorities of parents and youth regarding the health care transition process, as well as some valuable data about gaps in the system that can be used in future program planning.

The OGCSHCN continued to support a transition clinic for young adults with sickle cell disease at Johns Hopkins Hospital located in the Department of Internal Medicine. In this clinic, young adults with sickle cell disease are cared for jointly by the pediatric and adult hematologists for a

period of time prior to transfer of care to the adult hematology clinic. The clinic team, with the assistance of a community high school teacher, is working on an educational curriculum for this population, and there are also support group activities. The clinic transitioned 18 patients between the of ages 18-24 years in FY04.

The OGCSHCN also pays for specialty care and related services for young adults with special health care needs enrolled in the Children's Medical Services (CMS) Program until they reach the age of 22 years. Care may be covered until the age of 25 years in some special circumstances. The CMS Program staff work with YSHCN and their families to assist them with transitioning into programs for adults well in advance of the time when they will lose their eligibility for the CMS Program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support transition clinic activities including clinics for youth with sickle cell disease and youth with diabetes.		X		X
2. Provide payment for specialty care and related services for young adults with special health care needs until age 22 years.	X			
3. Conduct focus groups on health care transition and use findings in program planning.				X
4. Support monthly Transition Lecture Series for youth, families, and providers.		X		
5. Support Kennedy Krieger to survey pediatric and adult health care providers around their needs related to health care transition for CYSHCN.				X
6. Develop brief educational pamphlet for providers on health care transition for CYSHCN and advertise availability of a key contact at OGCSHCN.		X		
7. Work with other agencies involved in transitioning CYSHCN to disseminate information to youth and families about health care transition.		X		X
8.				
9.				
10.				

b. Current Activities

The OGCSHCN is providing funding to support a monthly Transition Lecture Series hosted by the Kennedy Krieger Institute, which is ongoing. This lecture series is open to youth, families, and providers, and has most recently featured topics such as "Informed Consent and Decision-Making Capacity," "Using Public Transportation and Learning to Drive," and "Financial and Estate Planning." The lectures are videotaped and copies are available for families to loan and view at home.

The OGCSHCN is supporting the Kennedy Krieger Institute to survey pediatric and adult health care providers in the community to find out what their needs are related to transition for CYSHCN. We are particularly interested in engaging adult providers, as our focus group data showed that a significant concern of families was finding an adult health care provider who was willing to take on their YSHCN as a patient, and who was knowledgeable about their child's particular health condition or disability.

c. Plan for the Coming Year

The OGCSHCN will continue to support the activities in process as noted above. Once the survey of pediatric and adult health care providers is complete, the OGCSHCN plans to work with the Kennedy Krieger Institute and the Maryland chapter of the AAP to create a brief transition pamphlet targeted at health care providers. One goal of this pamphlet will be to raise awareness in the provider community of the critical issues related to transition for CYSHCN and provide an overview of the steps health care providers can take to assist families with transition. In this pamphlet, we will also advertise the availability of a key contact who can visit a physician practice and do some more in-depth training around health care transition.

The OGCSHCN is providing support to the Division of Pediatric Endocrinology at Johns Hopkins Hospital to start a monthly transition clinic for adolescents with diabetes. Starting at age 17, these adolescents will be seen by the transition team consisting of a pediatric and an adult endocrinologist, as well as a pediatric and an adult diabetes educator. The adolescents will meet with the transition team for a year of visits, and then care will be transferred to adult endocrinology.

In the transition focus groups, families identified multiple areas of information about health care transition that they require and are lacking. In the coming year, the OGCSHCN plans to explore working with the Maryland Interagency Transition Council members such as the Maryland State Department of Education and the Developmental Disabilities Administration on ways to disseminate information about health care transition to youth and families already participating in other transition activities.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	80	80	80	80
Annual Indicator	78.4	77.9	80.8	83.3	83.3
Numerator	165832	167202	178483	184009	184009
Denominator	211520	214637	220899	220899	220899
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	85.1	86	86.9	87.8	90

Objective					

Notes - 2002

Source: 2001 - National Immunization Survey for children ages 19-35 months, Q3/200-Q2/2001 for 4:3:1:3:3 series

2002 - National Immunization Survey for children ages 19-35 months, Q3/2001-Q2/2002 for 4:3:1:3:3 series

Notes - 2003

Source: Immunization percentages - National Immunization Survey for children ages 19-35 months,CY 1999-2002 - 4:3:1:3 series; Data for 2003 is provisional and based on Q3/2002-Q2/2003. Population data - Vital Statistics Population estimates. 2003 data is not yet available.

a. Last Year's Accomplishments

Increasing percentages of Maryland children are being fully immunized. According to the Centers for Disease Control and Prevention (CDC)'s sponsored National Immunization Survey (NIS), in 2003/2004, 83.7% of Maryland children ages 19-35 months were fully immunized according to the 4:3:1:3 series. This percentage compares favorably with a national average of 80.5% for this time period and exceeds Maryland's target goal of 80% for this measure. Immunization rates for children in Baltimore City at 78.3% in 2003/2004 continued to lag behind the rest of the state (84.5%) according to the NIS.

The Community Health Administration, Center for Immunization is largely responsible for statewide immunization activities in Maryland. Ongoing activities to promote early childhood immunization in FY 2004 included the distribution of immunization educational materials to parents of every child born in the State, and continued administration of the Maryland Vaccines for Children Program which distributes free vaccine supplies to 800 active public/private provider sites enrolled in the Program.

The Maryland Legislature established guidelines for creating and implementing a statewide immunization registry, ImmuNet. Over the past decade, DHMH has worked to plan the development of this statewide registry with the purpose of increasing vaccination levels in Maryland. ImmuNet was implemented on June 18, 2004 and was successfully pilot tested. To date, ImmuNet contains over 475,000 immunization records and is used in 38 offices. The registry provides a consolidated vaccination record for children enrolled, provides reminder and recall notices, and prints forms for schools, camps, and day care.

In the late summer of 2004, more than 2,200 children were brought up-to-date on immunizations due to partnering between the Maryland Childhood Immunization Partnership, local health departments and private providers to host "Action to Immunize for School", an initiative to promote timely back-to-school vaccinations among low-income families. The Partnership also spearheaded a statewide campaign during National Infant Immunization Week that educated 7,900 families about the importance of timely immunizations.

MCH staff continued to support local health department efforts to inform consumers, communities and providers about the importance of immunizations. Although the majority of children are immunized in private physician offices, local health department clinics also continued to offer immunization services to Maryland children in need in 2003. MCH nursing staff in local health departments also educated families about the importance of immunization in home visiting and early childhood programs as part of a comprehensive approach to well child care. Educational materials to promote awareness of the need for immunization continued to be a part of all MCH outreach activities. WIC Program staff also determined the immunization status of their clients at every encounter.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute educationa materials to parents of every newborn in the state			X	
2. Fund immunizations clinics	X			
3. Continue to expand the state's immunization registry, Immunet				X
4. Provide insurance coverage for immunizations through Medicaid and MCHP		X		
5. Administer the Vaccines for Children Program				X
6. Promote immunizations through home visiting and early childhood programs			X	
7. Screen for immunization status in WIC and other programs			X	
8. Provide outreach and education to the public and health care providers to improve vaccination rates			X	X
9. Collaborate with the Maryland Immunization Partnership				X
10.				

b. Current Activities

The Center for Immunization provides support for the Maryland Childhood Immunization Partnership, a coalition of groups and providers interested in improving immunization rates in Maryland. The partnership meets regularly and is a major stakeholder in the implementation of ImmuNet. The Title V Program attends quarterly meetings of the Partnership.

The Center for Immunization continued to provide technical assistance to health providers enrolled in the Vaccines for Children Program in FY 2005. Ninety nine percent of enrolled Vaccines for Children Program providers received a comprehensive Assessment, Feedback, Incentives and eXchange (AFIX) visit in FY 2004. AFIX is a national immunization strategy to improve immunization coverage rates that helps states to assist providers with improving their immunization rates. The Center attributes a 3% improvement in Maryland's coverage rates for the 4:3:1:3:1 series between 2003 and 2004 to the AFIX visits.

c. Plan for the Coming Year

During the coming year, the Center for Immunization plans continue expansion of Immunet as well as outreach and education efforts directed at both providers and families to improve immunization levels. In addition, the Center for Immunization plans to develop and implement strategies to increase the immunization coverage rate as measured by the 4:3:1:3:3 series on the National Immunization Survey to 85% within the next five years from a baseline of 73% in 2001. Elimination of the six percentage point disparity in the vaccination rates among racial/ethnic groups will also be addressed. The MCH Program will continue to collaborate with the Center for Immunization on these objectives. Immunization issues will also be included as a part of early childhood grant development activities.

The Title V Program will also continue to support immunization outreach and education efforts provided by local health departments. Title V funds will continue to directly support Baltimore City's Immunization Registry, developed independently of Immunet. The City's Registry maintains a database of immunization and demographic information on Baltimore City children collected from pediatric providers. MCH staff identify children who are not up to date with their immunizations and refer them to a regular source of care.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	27.4	26	24.6	24.6	24.6
Annual Indicator	23.3	20.9	20.2	18.2	18.2
Numerator	2487	2298	2238	2085	2085
Denominator	106941	110054	110810	114645	114645
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.9	17.4	16.9	16.4	15.9

Notes - 2002

Source: Maryland Vital Statistics Administration

Notes - 2003

Data for 2003 is not yet available. Data for 2002 is based on the calendar year.

a. Last Year's Accomplishments

Maryland's teen birth rate declined for the tenth year in a row, falling to a rate of 18.2 births per 1,000 teens aged 15-17 in 2003. This decline continued to be attributed to increased outreach and education efforts, including abstinence only education and improved access to contraceptive methods including Emergency Contraception and Depo-Provera.

Maryland's Title V and Title X family planning programs continued to work to reduce teen pregnancies by discouraging premature childbearing, promoting preconception health care, and employing holistic approaches to teen pregnancy prevention in 2004. MCH staff involved in teen pregnancy prevention included a teen pregnancy prevention coordinator who also served as the abstinence education coordinator, an adolescent health coordinator and a pediatrician who oversees school and adolescent health issues.

Since 1970, the Title X Maryland Family Planning and Reproductive Health Program has provided comprehensive family planning, teen pregnancy prevention, preconception and preventive health services. In FY 2004, over 80 sites provided services to 70,000+ clients, about a third of whom were adolescents under the age of 20. Counseling regarding responsible sexual decision making including abstinence was offered to teen clients and parental involvement was encouraged. In many counties, significant efforts were made to provide education, counseling and medical services to young men. Most adolescents were served at no cost. The Healthy Teens and Young Adult Program, a model program offering a holistic approach to teen pregnancy prevention, continued to operate in three jurisdictions with high teen pregnancy rates. These projects served over 6,000 adolescents in FY 2004.

The Title V supported Maryland Abstinence Education and Coordination Program (MAECP) continued to support 14 community-based after school programs serving 350 pre-teens and teens, ages 9 to 18 in FY 2004. These programs offered activities that promote positive self-esteem and alternatives to risky behaviors while promoting an abstinence message. MAECP also sponsored its annual conference in October 2004 with over 500 adolescents and parents attending. MAECP also continued to collaborate with the Governor's Council on Adolescent Pregnancy (GCAP). GCAP works to reduce unplanned teen pregnancies through statewide planning and promotion of inter-agency collaboration. Title V was represented on this Inter-agency Council which planned the annual statewide Conference on Teen Pregnancy Prevention. This Council continued to fund Campaign for Our Children, a multi-media abstinence plus educational campaign established in 1987 to address Maryland's high teen birth rate.

GCAP and MAECP also collaborated to present a series of workshop on adolescent development and sexuality. The workshops were developed in response to requests from health professionals working in abstinence education and other teen programs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide comprehensive family planning and reproductive health services to 25,000 teens annually	X	X		
2. Promote sexual abstinence through afterschool programs funded the Maryland Abstinence Education and Coordination Program		X	X	
3. Hold an annual statewide abstinence conference for adolescents and parents			X	
4. Fund three Healthy Teen and Young Adult Programs that offer a holistic approach to teen pregnancy prevention	X			
5. Support a statewide multi-media abstinence plus campaign aimed at reducing teen pregnancy			X	
6. Conduct training, outreach and educational programs for providers and the community				X
7. Hold annual statewide conference on Teen Pregnancy Prevention				X
8. Provide support for the Governor's Council on Adolescent Pregnancy				X
9.				
10.				

b. Current Activities

The state's adolescent pregnancy and abstinence education programs underwent tremendous change in FY 2005. Earlier this year, both the Executive Director of GCAP and the state's abstinence education coordinator who also served as DHMH's teen pregnancy prevention coordinator, resigned. The GCAP resignation was partially in response to turmoil at the state level due to the abolishment of the Governor's Office of Children, Youth and Families (OCYF), under which GCAP was administratively located. Legislation creating OCYF was allowed to sunset on June 30, 2005, eliminating the Office and its mandated functions including GCAP. Governor Ehrlich has since created a new Office for Children with more streamlined functions and fewer staff. At the writing of this application, GCAP functions, minus any budgetary authority, are in the process of being transferred to CMCH.

One of the final GCAP activities was completion of a jurisdictional level assessment of adolescent needs related to teen pregnancy prevention. This data which was not received in time for inclusion in the 2005 Title V needs assessment will be reviewed and incorporated into planning activities in the next fiscal year.

During the last fiscal year, funding authority for abstinence education was transferred from MCHB to another federal agency. Subsequently, at the state level, abstinence funds were awarded to the Department of Human Resources (DHR). During this fiscal year, DHR and DHMH reached an agreement so that at the state level abstinence education funds in Maryland will continue to be administered by the Title V Program. CMCH has completed interviewing candidates for the Abstinence Education Coordinator position and is in the process of hiring a new coordinator.

c. Plan for the Coming Year

MCH plans for the coming year will include:
. Reviewing the state infrastructure for teen pregnancy prevention activities in Maryland;
. Continued administration of the Abstinence Education Grant; and
.Continued administration of components of the Title X and Title V programs directed at adolescent pregnancy prevention.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	30	30	30	30	30
Annual Indicator	23.7	23.7	23.7	23.7	23.7
Numerator	17703	17703	17703	17703	17703
Denominator	74696	74696	74696	74696	74696
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	30	30	30	30

Notes - 2002

Source: Survey of Oral Health Status of Maryland School Children conducted during the 2000-2001 school year. This survey is conducted every five years. During the interim years, it is

estimated that the percentages remain the same.

Notes - 2003

Source: Survey of Oral Health Status of Maryland School Children conducted during the 2000-2001 school year. This survey is conducted every five years. During the interim years, it is estimated that the percentages remain the same.

Notes - 2004

Data for this indicated is only collected once every five years in Maryland through a survey of school aged children statewide. Updated data should be available for next year's application.

a. Last Year's Accomplishments

According to The 2000-2001 Survey of Oral Health Status of Maryland School Children, the most recent year for which data is available, 24% of of Maryland third graders received dental sealants. White children were almost twice as likely as African American children to have sealants. The survey also identified that 42% of children had untreated dental decay, three times the national average. The Eastern Shore had the highest untreated dental decay (54%) followed by the Central Maryland region (48%).

The DHMH Office of Oral Health (OOH) has lead responsibility for promoting the oral health of Marylanders. Since 1996, OOH has awarded competitive grants to local health departments for a variety of public oral health initiatives. In FY 2004, OOH supported school and community-based dental sealant programs, operational in twelve jurisdictions, and serving 3,500 children. Twenty of Maryland's 24 local health departments operated some type of oral health program in 2004 ranging from limited preventive services to comprehensive clinical programs including restorative services. Last year, public health clinics located in Baltimore City and ten counties provided treatment services to over 2,300 children; many of whom were Medicaid recipients. Finally, local health departments partnered with schools and community programs to implement fluoride rinse and tablet programs to school aged children.

The Office of Oral Health continued to administer the P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness) Program in 2004. This Program trains dental professionals to recognize and report signs of abuse and neglect in their patients and is patterned after a program first developed in Missouri. The Program involves a 90 minute presentation covering such topics as physical and behavioral indicators of abuse and neglect, documentation of suspected cases and legal issues. Information on domestic violence and elder abuse has also been added.

The 2000 Title V Needs Assessment identified inadequate access to oral health services, as a major unmet need for children, particularly those enrolled in Medicaid. Health Choice, Medicaid's managed care program, funds comprehensive dental services for eligible children and adolescents. However, the Program has experienced difficulties in recruiting and maintaining sufficient numbers of oral health providers. OOH administers Maryland Dent-Care, a loan repayment plan which offers non-taxable loans to dentists willing to serve Medical Assistance recipients. In FY 2003, the numbers of Maryland dentists accepting Medicaid clients had increased to 330.

OOH continued to partner with MCH and other agencies in FY 2004 to develop policies, programs and activities. Title V continued to be represented on the DHMH Oral Health Advisory Committee which advises the Secretary on oral health related issues. OOH staff with the help of the Advisory Committee finalized a statewide Five Year Oral Health Plan in 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Fund a range of dental health services in local health departments including diagnostic, preventive and restorative services	X	X		X
2. Fund school based dental sealant programs	X			X
3. Administer a Loan Repayment Program for dentists serving low income populations (Office of Oral Health)				X
4. Continue to disseminate a Resource Guide for discounted dental health services		X		
5. Periodically survey children of all ages to ascertain oral health status and their families assess oral health needs				X
6. Participate on the DHMH Oral Health Advisory Committee				X
7. Provide outreach and education to promote oral health awareness			X	
8. Provide insurance coverage for dental health care through Medicaid and MCHP		X		X
9. Continue to administer the P.A.N.D.A. Project, a child abuse prevention program that trains dentists to recognize abuse				X
10.				

b. Current Activities

This fiscal year, the Oral Health Program Director, a champion for oral health in Maryland, left her position to purse other career opportunities. OOH was subsequently, administratively placed under the Center for Preventive Health Services and a new Director is being sought.

Inadequate access to oral health care, particularly for uninsured and Medicaid clients, continued as a concern for all areas of the state. Focus group participants, services providers and local health departments repeatedly voiced this concern to the 2005 needs assessment team. Title V funds continue to support oral health services in several jurisdictions in the state; however, the majority of funding for oral health flows through OOH.

In an effort to improve the state's oral health system, the OOH has contracted with the Children's Dental Health Project to complete an evaluation of the dental health infrastructure in Maryland. The methodology includes development of a framework to refine the 5-Year Oral Health Plan for Maryland based on assessment of needs and capacity. The goal is then build capacity to improve access to oral health services, improve the dental health infrastructure and analyze oral health policies.

The Maryland Legislature continued to utilization rates of dental health services by children in Maryland. Less than half of enrolled children are receiving some type of dental services and fewer still are receiving restorative services. This is occurring despite high rates of dental disease among children in our state. OOH and Medicaid are continuing to work to improve dental utilization rates for Medicaid enrolled children. A final report is due in the next fiscal year.

c. Plan for the Coming Year

During 2006, the MCH Program plans to review the results of the evaluation of the dental health infrastructure and determine additional ways for Title V to collaborate with OOH to improve access to dental services. The Title V Program will continue to partner with OOH through the Oral Health Advisory Committee.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5
Annual Indicator	2.4	3.0	3.0	2.9	2.9
Numerator	26	34	35	33	33
Denominator	1067199	1143763	1149643	1143353	1143353
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.6	2.5	2.4	2.2	2.1

Notes - 2002

Source: Maryland Vital Statistics Administration

Notes - 2003

Data for 2003 is not yet available. Data represents calendar year. Source: Maryland Vital Statistics Report, 2002

a. Last Year's Accomplishments

Injuries, including motor vehicle accidents remained the leading cause of death for children in 2003, a year in which 35 Maryland children under the age of 15 died in motor vehicle crashes. In FY 2004, the MCH Program continued to provide support and technical assistance to state and local Child Fatality Review (CFR) teams legislatively mandated to review child deaths in Maryland including those caused by motor vehicle accidents. Several jurisdictions identified motor vehicle accidents as a priority concern. The 2003 Child Death Report prepared by the MCH Epidemiogist for the state CFR team identified trends in deaths due to motor vehicle accidents.

State activities directed at preventing deaths due to motor vehicle accidents largely fall outside of the purview of the MCH Program. Maryland has enacted several strict safety belt laws. As a result of aggressive enforcement of these laws, Maryland has an 89% seat belt usage rate, one of the highest on the east coast. Children and young people up to 16 years of age must be secured in seat belts or child safety seats, regardless of their seating positions and may not ride in an unenclosed cargo bed of a pick-up truck. Maryland law also strictly forbids driving while impaired by alcohol or other drugs and the minimum lawful drinking age is 21 years.

Maryland law requires that every child under 6 years of age, regardless of weight, and every child weighing 40 pounds or less, regardless of age, must be secured in an approved child safety seat. Since the 1980's, the Maryland Kids in Safety Seats (KISS) Program has been the State's lead agency for promoting child passenger safety. KISS is housed in the Family Health Administration's Office of Health Promotion and funded by the Maryland Department of Transportation. Its mission is to reduce the number of childhood injuries and deaths by

educating the public about child passenger safety including the correct use of safety seats. Child safety seat inspections conducted in Maryland reflect that while an estimated 80% of the target population uses child safety seats; the vast majority (80-90%) of these seats are improperly installed. KISS continued to administer a child safety seat loaner program that provided seats to 1,355 low-income families in FY 2004. In addition, KISS offered child passenger safety certification training to law enforcement personnel and others.

The Center for Preventive Health Services (CPHS) funds local injury prevention programs, several of which address motor vehicle safety. CPHS also administers a project that links state crash and medical outcome data to identify the medical and financial consequences of motor vehicle crashes. CPHS uses this information to support preventive efforts.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct state and local child fatality review processes that include a review of deaths due to motor vehicle crashes				X
2. Enforce strict Maryland safety belt and DUI laws				X
3. Enforce laws requiring children of certain weights and at certain ages to use child passenger safety seats				X
4. Educate the public about safety seat laws and the correct use of child passenger safety seats			X	
5. Fund local injury prevention programs supporting motor vehicle safety		X	X	X
6. Monitor data and trends				X
7.				
8.				
9.				
10.				

b. Current Activities

Ongoing activities have continued in 2005. The MCH Epidemiologist completed the 2004 Child Fatality Review Report for the State Child Fatality Review Team. The report identified injuries, including those due to motor vehicle accidents, as a leading cause of child deaths. The CFR Team is examining motor vehicle crashes as a factor in the deaths of Maryland adolescents.

During National Child Passenger Safety Month in February 2005, jurisdictions throughout the state participated in child safety seat checks and community outreach and education activities.

c. Plan for the Coming Year

In FY 2006, the State Child Fatality Review Team and the MCH Program will continue to partner with other DHMH and state agencies to reduce child deaths due to motor vehicle accidents.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	60	60	60	60	60
Annual Indicator	59.9	61.0	61.3	61.0	63.0
Numerator	38851	37863	37051	36422	38178
Denominator	64841	62034	60399	59669	60572
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63.5	64	64.5	65	65.5

Notes - 2002

Source: Maryland Newborn Screening Database. Data is for calendar years 2001 and 2002 and excludes information on 7601 women in 2001 and 10,115 women in 2002 for whom breastfeeding status was not reported.

Notes - 2003

This measure is calculated on the calendar year (CY 2003). The data comes from the newborn screening slips and newborn screening data is complied on the calendar year to be consistent with the data reported to the National Newborn Screening and Genetics Resource Center. This excludes 11,864 women for whom breast feeding status was not reported.

a. Last Year's Accomplishments

More Maryland mothers are breastfeeding their babies at hospital discharge, both within the general and WIC populations. The percentage of mothers initiating breastfeeding at hospital discharge rose from 48.1% in 1991 to 63.0% in 2004. In April 2004, 52% of postpartum women enrolled in the WIC Program initiated early breastfeeding; compared to 13% of WIC mothers in 1991.

Other data sources indicate that up to 72% of new Maryland mothers are breastfeeding in the early postpartum period. According to the CDC's National Immunization Survey, in 2003,72% of Maryland mothers initiated breastfeeding, almost 40% continued breastfeeding at six months and 19 percent at one year. There is a significant racial disparity in breastfeeding with African American mothers less likely to breastfeed than mothers of other racial and ethnic groups.

The MCH Epidemiologist analyzed breastfeeding data from several sources to support needs assessment and planning activities for the 2006 Title V application.

Last year, both the Title V and WIC Programs continued to pro-actively promote and support breastfeeding efforts across the state. The two Programs continued to jointly provide leadership for the Maryland Breastfeeding Promotion Task Force. The Task Force's purpose is to identify strategies and coordinate efforts to increase Maryland breastfeeding rates. Representatives include Medicaid, hospitals, universities, the State's medical society, the March of Dimes, and the African American Breastfeeding Alliance. Dr. Maureen Edwards chairs the Task Force and

staff support is provided by the Title V Program.

The Task Force's work continued to be carried out with limited funding and the volunteer support of its four subcommittees: Workplace, Insurance, Health Professional Education, and Public Awareness. The Workplace Committee worked on development of a Toolkit for Maryland employers and the Public Awareness Committee developed a Speaker's Bureau.

Title V funds continued to support breastfeeding initiatives in several local health departments. For example, the MCH Program in Harford County promoted breastfeeding through the use of peer counselors. Breastfeeding was promoted in Title V funded Improved Pregnancy Outcome Programs funded in each jurisdiction. The WIC Program continued to promote breastfeeding as the preferred method of infant feeding for all clients. WIC has a Breastfeeding Coordinator and all WIC staff have received training in Advanced Lactation education. The Medicaid Healthy Start Home Visiting and Case Management Program promoted breastfeeding to enrolled pregnant and postpartum women.

Governor Ehrlich has recognized August as Breastfeeding Month in Maryland. Breastfeeding Month activities included the hosting of two satellite breastfeeding education programs, and participation in local breastfeeding promotion events.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide leadership for the Maryland Breastfeeding Promotion Task Force				X
2. Develop and implement a statewide plan to promote breastfeeding				X
3. Educate the public about the passage of "Right to Breastfeed" legislation in Maryland			X	X
4. Fund and support breastfeeding promotion activities such as peer counseling programs		X		X
5. Provide provider education programs that promote breastfeeding and encourage health providers to promote breastfeeding to their patients				X
6. Continue payment for breast pumps by the Medicaid Program		X		
7. Complete and disseminate a breastfeeding toolkit for employers to promote breastfeeding the workplace				X
8. Develop a Breastfeeding Speaker's Bureau				X
9. Continue to update and disseminate the state's Breastfeeding Resource Guide				X
10. Continue to update and maintain the Breastfeeding in Maryland Web site				X

b. Current Activities

Title V continued to support the agenda of the Maryland Breastfeeding Promotion Task Force and its subgroups in 2005, including a focus on provider education. A professional speakers' bureau for breastfeeding topics continues to make presentations at medical grand rounds as well as at other professional conferences. Articles concerning varying aspects of breastfeeding support are published in each edition of Perinatal Network, a new electronic newsletter for the Maryland perinatal community. Requirements for lactation support are included in the Maryland

Perinatal System Standards issued in October 2004.

Several breastfeed promotion activities have been implemented so far this year. With the help of a Preventive Medicine resident assigned to CMCH, the Task Force developed and launched a Breastfeeding in Maryland Website in January 2005. The Breastfeeding Website is available on the CMCH homepage and include links to the WIC Program and other resources as well as information for mothers, families, providers and the general public www.fha.state.md.us/mch/breastfeeding. Information for employers to support breastfeeding mothers in the workplace has recently been placed on the website.

The Maryland Breastfeeding Resource Handbook, has been updated by the Johns Hopkins School of Nursing, is currently being printed and will be available on the Website as well. A brochure is currently being finalized to be available for all new parents at hospital discharge. The pamphlet supplies information and resources for breastfeeding support in the early weeks postpartum.

WIC continues its ongoing support of breastfeeding for its clients and the community. To assist in further increasing breastfeeding rates among WIC enrolled women, the Maryland WIC Program was awarded additional funding from the U.S. Department of Agriculture to expand its Peer Counseling Breastfeeding Support Program to include at least six additional counties. This Initiative began implementation in 2005.

Plans are underway for additional activities in August, Breastfeeding Month in Maryland. The Title V Program is considering issuing a DHMH policy statement recommending human milk as the best source of nutrition for Maryland infants.

c. Plan for the Coming Year

During the coming year, the Title V Program plans to continue its ongoing activities that support breastfeeding as the norm for infant feeding. Plans for 2006 include:

Completion of a statewide plan which addresses promotion of breastfeeding in conjunction with the Maryland Breastfeeding Promotion Task Force. Limited staff support hindered completion of the Plan in 2005. The plan will include strategies for improving breastfeeding rates among African American women.

Examining options for implementing the National Breastfeeding Awareness Campaign in Maryland media markets as well as encouragement of positive media portrayals of breastfeeding as the norm for infant feeding in Maryland.

Identifying an influential spokesperson for breastfeeding promotion to assist in a public awareness campaign.

Establishing DHMH as a role model for breastfeeding support in the workplace for other state agencies and the private sector. A Breastfeeding Support Room for employees has been an ongoing DHMH project since 1996. A process for DHMH to designate "Breastfeeding Friendly Workplaces" is being explored.

Providing outreach and technical assistance to other state agencies to implement breastfeeding promotion activities appropriate to their area of responsibility, e.g., MSDE curriculum development, child care provider education. Encouraging use of books for young children with positive portrayal of breastfeeding is an example of this activity. Seeking funding

to address breastfeeding promotion activities.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25	80	85	90	90
Annual Indicator	21.4	78.7	62.7	93.7	91.2
Numerator	14769	54210	42997	66297	64793
Denominator	69152	68916	68529	70783	71083
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

There was a major compliance problem on the part of hospitals and audiologists in terms of reporting to the State. Screening was being done but the results were not being reported to the State. This was first addressed with intensive hospital visiting and improved dramatically when the blood spot newborn screening card was modified to collect the hearing screening data. CY 2002 data is much better (85.7% screened) than FY 2002 data (only 62.7% screened).

Notes - 2004

Newborn hearing screening data is reported by fiscal year, FY 2004.

A new performance objective is not formulated. Newborn hearing screening data is collected on the blood spot screening lab slip. We are not sure if we can sustain our historical strength in this area because of the problems of obtaining data from the commercial laboratory. They do not report data on all babies, only those born in Maryland hospitals with whom they have a contract. For example, they will not report on home births. While we continue to work with them to improve the situation, we are concerned that the chance for us to miss a baby or lose one between the cracks has increased.

a. Last Year's Accomplishments

In FY04, 91.2 % of the babies born in Maryland were screened for hearing. FY04 was a difficult year, as the OGCSHCN suffered the loss of both audiologists in the UNHS Program. The program director left and his position was cut as a result of the State budget deficit. The junior

audiologist struggled on alone with the help of audiology students from Towson University, but had to reduce her hours and eventually resigned at the end of CY04 due to serious illness in her family. Therefore, the manpower was not available to continue intensive hospital visiting and reporting began to fall off. In addition, the licensing of Pediatrix as a newborn screening lab in Maryland has created challenges for the UNHS Program. The hearing screening results are reported on the newborn screening lab slip, and an increasing fraction of the hospitals are using Pediatrix as their newborn screening lab instead of the State lab. Data reporting from Pediatrix has been imperfect; there are also some unresolved data compatibility issues with the UNHS computer system.

Despite the shortage of personnel, the OGCSHCN was able to support a number of activities in the past year aimed at both parents and professionals through the work of its partners. The Maryland School for the Deaf was funded to conduct a workshop for families around cochlear implants and to purchase the ASL Access Video Collection for their parent resource library. The Hearing and Speech Agency was able to print copies of the "Keys to Communication" tutorial and resource notebook developed for families of newly diagnosed young children with hearing loss, and to disseminate these to local Infants and Toddlers Programs for lending to families.

In terms of professional education, funds were again given to the Maryland State Department of Education to conduct workshops for Infants and Toddlers case managers. The workshops addressed how to understand the grieving process and support families of young children diagnosed with hearing loss. The OGCSHCN also partnered with the Hearing and Speech Agency to conduct an educational conference for audiologists. Two identical conferences were held recently, one in Baltimore and one in Montgomery County, around the importance of early identification and intervention for hearing loss. The conferences were reasonably well attended, and we are awaiting results of the participant evaluation to determine how the conferences were received by the audiology community.

The UNHS program's partners were also successful in gathering data this past year that we hope will be useful in future program planning. An audiology student from Towson University surveyed the parents of babies confirmed with hearing loss in FY03 to ascertain outcomes and age at intervention. The Chapter Champion from the Maryland AAP surveyed pediatricians to determine their educational needs around UNHS. There was also a survey of audiologists, the results of which were used in the planning of the conference noted above.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support hearing screening for all Maryland babies			X	
2. Provide follow up assuring that all abnormal or inadequate results are followed to resolution	X	X	X	
3. Provide parent education materials related to hearing screening and hearing loss in multiple languages		X	X	
4. Provide education and training to hospitals		X	X	X
5. Provide educational activities around newborn hearing screening for audiologists		X		X
6. Provide educational activities around newborn hearing screening for pediatricians and ENTs		X		X
7. Enhance the follow up database for ease of reporting			X	X

8. Work with commercial newborn screenuing laboratory to assure complete State data			X	X
9. Collaborate with the Maryland Early Intervention Program in the evaluation and habilitation of hearing impaired infants		X		X
10. Collaborate with the Maryland Early Intervention Program and the Maryland Department of Education to collect outcome data			X	X

b. Current Activities

The OGCSHCN is fortunate to currently have an MD/PhD visiting scholar trained in pediatrics and genetics who has been filling in and providing follow up for the more complex cases that a program audiologist would have handled. In addition, the OGCSHCN was successful in reclassifying another position to the audiologist series so as to be able to hire a new program director. This was only approved because funding for the position was available from the MCHB newborn hearing screening grant. Exemptions from the hiring freeze for both audiologist positions have been obtained and recruitment is ongoing. In the meantime, it was necessary to hire a consultant audiologist to write a grant proposal for continued MCHB funding of Maryland's UNHS Program. We are still awaiting news of whether Maryland will receive another year of grant support.

After submitting Maryland's UNHS grant proposal, the audiology consultant made a presentation to the Advisory Council on Universal Newborn Hearing Screening describing the successes and the challenges of UNHS in Maryland. Some of the challenges noted and discussed were lack of consistent and effective protocols for the diagnosis and management of hearing loss in very young infants, loss to follow-up of at-risk infants, and problems with communication between professionals. The President of the Maryland Academy of Audiology has since begun the work of convening a work group of audiologists and other UNHS stakeholders with the goal of fostering collaboration among professionals and more specifically to review, adopt and/or develop screening, diagnostic, and intervention protocols for hearing loss in infants and young children. The first meeting of this work group is scheduled for early August, and will be attended by staff from the UNHS Program.

c. Plan for the Coming Year

The most important effort for the immediate future is to bring 2 new audiologists on board and get them out visiting hospitals to maintain reporting. In addition, a major effort will be made to improve data exchange with Pediatrix. There are also improvements to the UNHS database planned; the extent of these will be determined in part by the availability of funds to support the work of a computer programmer. The database enhancements have been delayed by the decision of the State lab not to implement the updated lab database funded for them by the OGCSHCN but to wait for the new standard national database being produced for the Association of Public Health Laboratories and the CDC.

The UNHS Program hopes to target a number of areas identified as problem spots in the follow-up continuum in the coming year. For instance, NICU follow-up will be targeted as analysis of program data shows that a significant fraction of the infants not being properly tested before hospital discharge spend time in the NICU. In addition, we have noted that the number of infants failing the initial hearing screen who do not receive a rescreen by 6 weeks is relatively high, and the staff in the UNHS Program continue to meet resistance from parents and medical personnel when calling to suggest rescreening. Educational efforts will need to be targeted here.

The UNHS Program will participate in the work group convened by the Maryland Academy of Audiology in order to strengthen relationships with the professional community and assist in protocol development. The visiting fellow has already started drafting a detailed follow-up

protocol for infants who have failed the one month rescreen, and a protocol for the identification of hearing impaired infants with genetic syndromes. These should be completed in the coming year.

The UNHS Program will work more closely with the Maryland State Department of Education (MSDE) in the coming year in order to improve the long term follow up of hearing impaired infants identified through the Program and the collection of outcome data. An interagency agreement between MSDE and the Maryland Department of Health and Mental Hygiene (as well as other State agencies) was recently updated and included data exchange provisions; however, we may need to pursue a more specific Memorandum of Understanding in order to accomplish this goal.

In the more distant future, the UNHS Program hopes to improve its ability to identify syndromes in children with hearing loss, and provide genetic evaluations and mutation analysis in a more organized fashion.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10	10	10	10	10
Annual Indicator	7.4	9.1	10.0	9.6	9.6
Numerator	100357	124607	137992	140000	140000
Denominator	1356172	1369311	1379925	1452879	1452879
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9.5	9.4	9.3	9.2	9.1

Notes - 2002

Source: 2001 Current Population Survey, U. S. Census Bureau.

Notes - 2003

Source: Maryland Health Care Commission, Health Insurance Coverage in Maryland through 2002. Based on Current Population data for 2001-2002 for children ages 0-19. Percentage applied to children ages 0-17. Data for 2003 is not available.

a. Last Year's Accomplishments

Over 740,000 Marylanders lacked health insurance coverage in 2002-2003. An estimated 140,000 of the state's uninsured were children between the ages of 0-18. An estimated 9 to 10% of children were uninsured in 2002-2003. Between 2001-2002 and 2002-2003, the state's uninsured non-elderly population increased by 60,000 while the numbers of uninsured children

declined by 10,000. The state's MCHP program which provided insurance coverage to 150,643 children at some point during FY 2004 is partially credited with the decline in uninsured children. Black (13%), Hispanic (24%) and Asian (15%) children were three to six times more likely than White children (4%) to be uninsured.

Medical Assistance and the Maryland Children's Health Insurance Program (MCHP) continued to provide health insurance coverage for low income children. MCHP, which is administered by the Medicaid Program, provided access to health insurance coverage for significant numbers of uninsured Maryland children. During federal fiscal year 2003, enrollment in MCHP exceeded 150,000. The Children's Medical Services Program within the OGCSHCN continued to provide coverage for specialty care for uninsured and underinsured CSHCN in family incomes below 200% of the federal poverty level. Since Medical Assistance also covers this same income group, most of the children served are undocumented.

The State's fiscal situation impacted the ability to continue and maintain Medicaid Program expansions to cover increasing number of uninsured children. Maryland expanded MCHP coverage through MCHP Premium in July 2001 cover to children in families with incomes between 200 and 300 percent of the Federal poverty level. Families are required to pay a premium for coverage. An estimated 14,000 additional children were thought to be eligible for MCHP Premium coverage. In 2003, the Maryland Legislature enacted changes in the MCHP Premium Program. The Private Option Program of MCHP Premium was repealed and no new children were allowed to enroll. The 200 currently enrolled children continued to be served, but were switched from their employer sponsored plans to HealthChoice. In addition, co-pays were required for MCHP enrollees with incomes between 185 and 200% of poverty.

The 2004 General Assembly repealed the 2003 restrictions to the MCHP Premium Program. This resulted in removal of the freeze on the enrollment for children in families with incomes between 200 and 300% of the federal poverty level. In addition, children whose families pay for coverage because their family income falls between 185 and 200% of the poverty level will no longer have to pay a premium to continue coverage. Medicaid and MCH Programs in local health departments continued to provide outreach to communities and families to inform them of changes to the law.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide health insurance coverage for eligible low income children through Medicaid and MCHP		X		
2. Refer families to Medicaid services through the MCH Hotline		X		
3. Provide outreach efforts to enroll eligible children into the Medicaid Program		X		
4. Disseminate resource information that lists sources of financial assistance for health care		X		
5. Refer families to community health centers, both federal and state qualified, that provide services on a sliding fee scale basis		X		
6. Provide coverage of eligible CSHCN through the OGCSHCN		X		
7. Assess health needs and issues confronting uninsured children and families				X

8.				
9.				
10.				

b. Current Activities

In FY 2005, the Title V Program, including local health department based MCH programs, continue to support the Medicaid Program in enrolling eligible children and adolescents. Coordinated outreach efforts with local health departments, community health centers, managed care organizations, and other public and private providers working with low income uninsured populations will continue. Outreach strategies will continue to include distribution of MCHP/Medicaid eligibility information to schools, licensed day care centers, Head Start programs, community events and health fairs; and periodic media campaigns promoting the MCH Information and Referral Hotline. The MCH Hotline will continue to refer pregnant women and families to local health departments and other program sites that determine eligibility for Medical Assistance Programs.

c. Plan for the Coming Year

Ongoing activities will continue.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85	85	85	85
Annual Indicator	85.2	96.3	77.3	77.3	77.3
Numerator	333790	315568	269610	286398	286398
Denominator	391582	327837	348914	370303	370303
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	78	78	78	78

Notes - 2002

Source: Maryalnd Medical Assistance Program data for federal fiscal years 2001 and 2002. Includes SCHP coverage groups and covers children under the age of 20.

Notes - 2003

Source: Maryland Medical Assistance Program,. Data is for the Federal Fiscal Year.

a. Last Year's Accomplishments

The Maryland Medical Assistance Program serves as the major source of publicly sponsored health insurance coverage for children and adolescents lacking access to employer sponsored and private programs. Both Medicaid and MCHP, the state's SCHIP Program and a Medicaid expansion, provide access to a broad range of health care services for eligible low income children. In State fiscal year 2004, approximately one third of Maryland children and adolescents under age 19 were enrolled in the Medicaid Program at some point during the year. This percentage includes enrollment in MCHP. Although the true number of eligibles is unknown, the Program estimates that over 90% of potentially Medicaid eligible children received a service paid by the Medicaid Program in FY 2004.

The MCH Program continued to support the Medicaid Program to enroll eligible children and adolescents in FY 2004. Outreach strategies include a grassroots information dissemination campaign involving collaboration with State agencies; advocacy and community-based groups and provider organizations; a general public media and advertising campaign; and streamlining of the application process. The State continued to coordinate its outreach efforts with local health departments, WIC Program sites, community health centers, social services agencies, managed care organizations, and other public and private providers who have historically served uninsured low income populations. In addition, the OGCSHCN sends a postcard to the parents of all Maryland children who are new SSI recipients informing them of their eligibility for Medicaid.

The MCH Hotline number (1-800-456-8900) was advertised on bus and subway placards. MCH Hotline workers refer callers to sites that determine eligibility for Medical Assistance Programs as well as to other MCH programs and services. Families seeking coverage for CSHCN through the Children's Resource Line operated by OGCSHCN are also referred to Medical Assistance when appropriate. In addition, flyers containing eligibility information were distributed through schools, licensed day care centers, and Healthy Start programs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide insurance coverage for eligible low income children through the Medicaid Program		X		
2. Conduct outreach and education to promote the availability of Medicaid services		X		
3. Promote the MCH Hotline as a referral source for Medicaid services		X		
4. Estimate the numbers of children in the state eligible for Medicaid				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Family Health Administration and the Medicaid Program completed a revised cooperative agreement in fulfillment of the federal requirement that state agencies that operate Medicaid, MCH, Family Planning and WIC must enter into respective interagency agreements. Maryland's agreement documents key areas of program coordination among the respective federally

funded programs. The goal is to ensure efficient us of resources across all programs so that services provided to pregnant women, children and their families will result in improvements in health.

c. Plan for the Coming Year

Ongoing activities described above will continue in FY 2006.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.9	1.9	1.9	1.9	1.9
Annual Indicator	1.9	2.0	1.9	1.9	1.9
Numerator	1388	1446	1422	1440	1440
Denominator	74226	73152	73250	74865	74865
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.6	1.4	1.3	1.2	1.1

Notes - 2002

Source: Maryland Vital Statistics Administration. Data for 2002 will not be available until late Fall 2003.

Notes - 2003

Data for 2003 is not yet available. Data for 2002 represents the calendar year. Source: Vital Statistics Administration

a. Last Year's Accomplishments

In 2003, two percent of Maryland babies were born at very low birth weights. Disorders related to short gestation and low birth weight contributed to 22% of infant deaths in 2003. Maryland continues to have one of the nation's highest low birth weight birth rates. Maryland efforts to reduce low birth weight births and improve birth outcomes continued to focus on strategies such as (1) promoting access to family planning, preconception health and prenatal care services, (2) improving access to health insurance coverage, (3) decreasing smoking during pregnancy and (4) perinatal systems building including FIMR in 2004.

Family planning and prenatal care services continued to be offered by MCH programs in local health departments. Each local health department provided preconception health counseling, including folic acid promotion to family planning clients. Six of the 24 local health departments offered or supported prenatal care clinics which largely served uninsured and/or undocumented

women in 2004. The MCH Hotline linked women with services that contribute to healthy birth outcomes. MCH staff in local health departments continued outreach and education to identify pregnant women and families eligible for Medical Assistance and MCHP. Pregnant women with incomes under 250% of the Federal Poverty Level are eligible for Medicaid/MCHP benefits.

Local health departments continued to collaborate with the Medical Assistance Program to improve health outcomes for pregnant women and infants by providing home visiting and care coordination services through Medical Assistance's Healthy Start Program. (This state funded program is not part of the federal Healthy Start Initiative). Healthy Start nurses provided case management, home visiting services, and referral to medical and social support services to at risk women enrolled in Medicaid, including women at risk for premature labor, a risk factor for low birth weight births. More than 14,000 at risk women were identified and referred by providers to the Healthy Start Program in FY 2004.

This past year, each local health department continued to receive Title V funding through the Improved Pregnancy Outcome (IPO) Program to address core public health functions that benefit all pregnant women and their newborns. IPO supports a perinatal coordinator in each jurisdiction to act as a liaison between the local community and both public and private health care providers. The goal is to establish coordinated, interdisciplinary approaches for assuring quality patient care services, educational activities, and community-based efforts directed at improving pregnancy and birth outcomes.

CMCH has lead responsibility for planning and organizing the state's fifth Perinatal Health Conference held in September 2004. The conference's theme was Primary Prevention Strategies in Perinatal Care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Medicaid coverage of prenatal care services for pregnant women with incomes up to 250% of the poverty level		X		
2. Fund fetal and infant mortality review (FIMR) processes that cover every jurisdiction of the state				X
3. Fund and provide family planning and reproductive health services	X			
4. Fund nurse home visiting and case management services for at risk women in every jurisdiction		X		
5. Support perinatal health conferences to educate providers and others about LBW				
6. Promote access to prenatal care and insurance coverage through the MCH Hotline		X	X	X
7. Continue to fund and offer prenatal care services in selected jurisdictions	X	X		X
8. Support initiatives to reduce smoking and alcohol use during pregnancy				
9. Develop and disseminate perinatal standards of care				X
10.				

b. Current Activities

The Title V funded Crenshaw Initiative continues to support regional perinatal coordination

efforts to reduce low birth weight and infant mortality as well as programs that are responsive to the recommendations of local FIMR programs. A common theme that defines these programs is enhanced communication and collaboration among perinatal providers for making system improvements. Current projects include: outreach to African American and immigrant women in Frederick County, a regional perinatal advisory group focusing on providing screening tools for perinatal infections. This Initiative is being expanded to include funding for the state's two major teaching universities to provide statewide availability of on-site and telemedicine consultation for high risk pregnancies to community-based providers throughout the state in order to improve the quality of perinatal care in Maryland.

As a result of an increase in the number of infant deaths in 2003, Baltimore City requested permission to reallocate Title V dollars to develop a new Infant Survival Initiative. Under this Initiative, maternal and infant health nurses are replicating the City's federal Healthy Start model and providing intensive home visiting and case management services to high risk pregnant women, infants and toddlers. These services will be provided outside the Healthy Start catchment areas. An advisory group process called BabyStat has been organized to monitor the Initiative's progress and a Title V nurse consultant attends these bi-monthly meetings. The Initiative is projecting to serve 500 to 600 high risk families in FY 2005.

A Perinatal Disparities Work Group was convened to examine perinatal disparities in birth outcomes. African American babies are more than twice as likely as White babies to be born at low birth weight and to die within the first year of life. The Work Group is exploring the role of stress including racism as a stressor as a contributing factor to the disparities. A final Work Group Report is being completed.

CMCH is partnering with the March of Dimes to disseminate information about its campaign to reduce the numbers of premature births. CMCH is continuing to sustain Folic Acid Council activities that were originally funded through a grant from the March of Dimes.

c. Plan for the Coming Year

Ongoing activities as described will continue in 2006.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5.2	5.2	5.2	5.2	5.2
Annual Indicator	7.3	7.4	7.1	6.2	6.2
Numerator	26	27	27	24	24
Denominator	356119	365153	379052	386908	386908
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	5.9	5.7	5.6	5.4	5.3

Notes - 2002

Source: Maryland Vital Statistics Administration. Data is for the calendar year. Data for 2002 will not be available until Fall 2003.

Notes - 2003

Data for 2003 is not yet available. Data for 2002 represents the calendar year. Source: Vital Statistics Administration

a. Last Year's Accomplishments

Homicide and suicide are leading causes of deaths among adolescents in Maryland. Twenty four adolescents between the ages of 15 and 19 committed suicide in Maryland in 2003, a rate of 6.2 deaths per 100,000 youth aged 15-19. Suicide is linked to mental health issues, particularly depression, stress and loneliness. These mental health issues were identified as major problems for many Maryland adolescents during the FY 2000 needs assessment.

The Maryland Mental Hygiene Administration (MHA) has lead responsibility for administering programs to prevent adolescent suicide among youth and young adults ages 15-24. Maryland is nationally recognized as a leader in reducing adolescent suicide rates among this age group. For the past 12 years, October has been proclaimed as Youth Suicide Prevention Month in Maryland. During October, MHA sponsors an annual conference on youth suicide and other educational events. Funds are also awarded to local school districts to sponsor educational events. A full time Suicide Prevention Coordinator supports these activities.

Maryland was the first State in the nation to offer a toll free decentralized hotline service to address the needs of troubled youth. The 24-hour toll free Youth Crisis Hotline (1-800-422-0008) is staffed by trained counselors using a decentralized system which enables the counselor to access or refer the youth to local agencies for assistance. Throughout its 14 year history, the hotline, has been very successful in intervening with youth considering suicide.

Maryland's Title V agency continued to be represented on the Governor's Inter-Agency Workgroup on Youth Suicide Prevention. This workgroup and its subcommittee planned the annual conference and Youth Suicide Prevention month activities, organized public education activities, and developed special interest outreach programs for teens at high risk for suicide.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund and administer a statewide Youth Crisis Hotline (Mental Hygiene Administration)		X	X	
2. Collaborate in planning and supporting the Annual Suicide Prevention Conference			X	X
3. Fund school based suicide prevention activities (Mental Hygiene Adminstration)		X	X	
4. Conduct state and local child fatality review processes				X
5. Collaborate with other state and local agencies to address adolescent health issues and needs including mental health problems such as				X

depression				
6. Support the work of the state's full-time Suicide Prevention Coordinator (Mental Hygiene Administration)				X
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Program's Adolescent Health Coordinator continues to be actively involved in suicide prevention activities under the leadership of MHA. Planning for the October 2005 adolescent suicide prevention conference is underway.

CMCH is the co-sponsor of the Annual School Health Interdisciplinary Program from August 1-4, 2005. This week long continuing education program provides intensive training on all components of coordinated school health including school health services, health education, nutrition and mental health. The target audience ranges from school administrators to school health nurses to mental health professionals.

Adolescent health issues, including mental health problems such as suicide and depression were addressed by the Adolescent Workgroup for the Title V needs assessment. Depression was identified as a major cross-cutting problem. Recommendations for improving adolescent mental health included the need for more screening and early intervention programs, more mental health professionals serving children and teens, and greater family and public awareness of teen mental health issues. The Title V Program is currently examining strategies for addressing depression across the lifespan.

c. Plan for the Coming Year

The Mental Hygiene Administration, in collaboration with the Governor's Interagency Workgroup on Youth Suicide Prevention and CMCH, will continue to plan and implement the annual statewide adolescent suicide prevention conference, periodic media campaigns and school based youth suicide prevention programs.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	90	90
Annual Indicator	86.7	87.0	86.0	87.0	87.0
Numerator	1018	1080	1033	1080	1080
Denominator	1174	1242	1201	1242	1242

Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	87.5	88	88.5	89	89.5

Notes - 2002

Source: Maryland Vital Statistics data for calendar year 2001. Data for 2002 will not be available until Fall 2003.

Notes - 2003

Source: Maryland Vital Statistics Administration. Data for 2003 is not available. Includes Maryland resident recorded events only.

a. Last Year's Accomplishments

DHMH continued to work to improve hospital specific birth outcomes and to lower neonatal mortality rates by ensuring that all very low birth weight infants are born at the appropriate subspecialty center. In 2002, according to the Vital Statistics Administration, 87% of very low birth weight infants born in Maryland were delivered at high risk facilities; a slight increase over the 2002 level.

Seeking to further strengthen the state's perinatal care system, in FY 2003, former Secretary Sabitini directed FHA to develop and implement a Perinatal Systems of Care Initiative to further improve birth outcomes in Maryland. CMCH was given lead responsibility for planning the Initiative. This directive resulted in development of a plan that included (1)reviewing and updating perinatal care standards, and development of a collaborative partnership with the state's two academic medical centers to institutionalize a system of high risk outreach, consultation, referral and transport in Maryland.

Several actions took place in 2004 to implement the Perinatal Systems of Care Initiative. The State's Perinatal Clinical Advisory Committee reconvened in March 2004 to refine perinatal standards of care for hospital delivery and infant services. Two subcommittes have been formed; one to discuss obstetrical issues and the other to examine neonatal care issues. Dr. Maureen Edwards is the CMCH representative to this Committee.

In FY 2004, Title V funding was provided to the University of Maryland School of Medicine to began overseeing implementation of a long term plan for development of a comprehensive coordinated statewide perinatal care system. This involves (1)assessing the need for high risk perinatal consultation, education, technical assistance and referral in each region, (2) conducting high risk consultation clinics, grand rounds and educational sessions, (3) developing a high risk referral and transport system, and (4)collecting, analyzing and monitoring perinatal care data.

Through a subcontract, Title V funding to the Johns Hopkins School of Medicine was used to provide perinatal consultation on high risk obstetric patients through regularly scheduled monthly on-site clinic sessions in three regions (Eastern Shore, Southern Maryland,Western Maryland). The University provided 24 hour risk assessment and clinical consultation for both emergent and nonemergent situations as well as provide continuing medical education tailored to the needs of local providers. This system of high risk perinatal outreach had been informally developed and pioneered by Dr. David Nagy at Hopkins. Following his recent untimely death, the system is now being formally institutionalized.

The Perinatal Outreach activities included funding to local health departments in Montgomery

and Prince George's counties to provide prenatal care services for low income immigrant women. These counties were selected because of the high number of immigrant women seeking services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review and update perinatal care standards				X
2. Provide technical assistance to improve compliance with perinatal standards				X
3. Designate perinatal centers				X
4. Conduct site reviews of specialty perinatal centers				X
5. Collect and analyze perinatal data				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Maryland Perinatal System Standards were originally developed in 1995-1998 by a departmental advisory committee as a set of voluntary standards for Maryland hospitals providing obstetrical and neonatal services. The Standards have been incorporated into the regulations for perinatal referral centers by the Maryland Institute of Emergency Medical Services Systems (MIEMSS) as well as into the Maryland Health Care Commission's State Plan regulations for obstetrical units and neonatal intensive care units.

In 2004, the Department of Health and Mental Hygiene reconvened its Perinatal Clinical Advisory Committee, a multidisciplinary committee representing 16 Maryland professional organizations, to review and update the Standards. The new guidelines are consistent with the Guidelines for Perinatal Care, 5th Edition, 2002 issued by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists as well as the AAP 2004 Policy Statement on Levels of Neonatal Care. Revision of the Maryland Standards was completed in October 2004. The Standards have been disseminated statewide and can be found on the CMCH Website: www.fha.state.md.us/mch.

Title V funding to the University of Maryland supports a statewide telemedicine program that offers provider and patient education and outreach consultation. The provider education component uses a real time web based training curriculum, Living Text of Obstetrics. The telemedicine consultative component enhances direct perinatal provider outreach by allowing increased access to consultations and at the same time allowing rural patients to remain in their communities instead of traveling long distances. Piloting of this program is occurring in selected rural jurisdictions before it is implemented statewide.

c. Plan for the Coming Year

The Perinatal Systems of Care Initiative described above will continue in FY 2006.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	90	90
Annual Indicator	86.4	83.7	84.1	83.7	82.2
Numerator	62421	59789	61603	61834	60235
Denominator	72206	71425	73250	73876	73239
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83.9	84.1	84.3	84.5	85

Notes - 2002

Source: Maryland Vital Statistics Administration. Data is for the calendar year and excludes births for whom prenatal care status was unknown.

Notes - 2003

Data for 2003 is not yet available. Data represents the calendar year. Excludes births for which timing of prenatal care was unknown. Source: Vital Statistics Report, 2002.

a. Last Year's Accomplishments

Early prenatal care rates continued to decline to 83.7% in 2003; more than 4 percentage points lower than the 1997 rate of 88%. Early prenatal care percentages declined for women enrolled in both Medicaid and non-Medicaid programs and within certain jurisdictions, namely Baltimore City and Prince George's County. In 2003, early prenatal care percentages were highest for non-Hispanic White women (90.9%) and lowest for Hispanic women (70.1%). By jurisdiction, early prenatal care percentages ranged from a low of 73.8% in Baltimore City to a high of 95.9% in Carroll County. For African American women, percentages ranged from a high of 91.8% in Howard County to a low of 69.8% in Frederick County. It appears that improvements are occurring in the jurisdictions with the highest rate, while just the opposite is occurring in the areas with the lowest rates.

The reasons for the decline remain unclear; however, there are suspected causes. FIMR reports, for example, suggest that some managed care providers are requiring women to wait until the 12th week of pregnancy before seeking care. Physicians reportedly are less likely to accept new clients due to malpractice and reimbursement concerns. PRAMS data for 2003 indicate the following reasons for why Maryland women failed to get prenatal care as early as they wanted: (1) not aware of pregnancy (34.4%); couldn't get earlier appointment (28.5%); didn't have insurance, money or Medicaid (26.2%); and doctor or health plan wouldn't start care earlier (10.6%).

Medicaid continued to cover the cost of prenatal care services for over 25,000 eligible pregnant women with incomes up to 250% of the poverty level in FY 2004; approximately one third.

Governor Ehrlich awarded supplemental funding to provide care to increasing numbers of uninsured immigrant women in three jurisdictions -- Prince George's, Anne Arundel and Montgomery counties.

The Title V funded Improved Pregnancy Outcome and Crenshaw Perinatal Health Programs also promoted prenatal care services. State and Medicaid funded Healthy Start nurses and other home visiting programs continued to promote access to early and continuous prenatal care as well as the need for screening for infections, especially among high risk pregnant women. Home visiting and case management services for pregnant women continued to be provided in every Maryland jurisdiction. The MCH Hotline continued to refer pregnant women to private providers, community health centers, and other sources of prenatal care in 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Medicaid coverage of prenatal care services for pregnant women with incomes up to 250% of the family poverty level		X		
2. Refer women to prenatal care services through the MCH Hotline		X		
3. Promote the importance of early prenatal care in nurse home visiting programs			X	
4. Contine to offer preconception health counseling in family planning programs that supports early prenatal care		X		
5. Continue to offer local health department based prenatal care services to uninsured low income women	X			
6. Fund prenatal care services for immigrant pregnant women	X			
7.				
8.				
9.				
10.				

b. Current Activities

Maryland's growing population of undocumented pregnant women has resulted in a greater proportion of direct care once being provided or supported by LHDs. These women are not eligible for Medicaid covered prenatal care although the cost of delivery is covered under emergency Medicaid and their infants become eligible for coverage as new American citizens.

The majority of immigrant women in need are Hispanic, but a sizable proportion are from Africa and Asia. Ten counties (Anne Arundel, Caroline, Dorchester, Howard, Montgomery, Prince George's, Somerset, Talbot, Wicomico and Worcester) have established public-private partnerships to assure access to care for immigrant pregnant women. Over 3,000 women were served in FY 2004, the majority in Montgomery and Prince George's County programs. Hispanic women have the lowest rates of early prenatal care usage in Maryland; however, their pregnancy outcomes are among the best.

Early in the fiscal year, local newspapers reported that rising malpractice premium rates were causing many physicians to the leave the practice of obstetrics and that fewer medical students are choosing residencies in obstetrics. Med Mutual, the state's largest malpractice insurance company has raised rates by 28% 41% in recent years. As a result, Governor Ehrlich convened a special Maryland General Assembly Session to pass a malpractice reform bill. The Governor

has appointed a Malpractice Task Force to a conduct a comprehensive review of Maryland's medical malpractice crisis.

Local health departments, particularly in rural areas of the state, expressed concerns about the numbers of OB/GYNs who are forfeiting their obstetrical practices and focusing on gynecology. One local health department noted that the fear is that the local emergency department will become the delivery site for many women and that even fewer women will have access to prenatal care services. It was indicated that obstetricians are being more selective about who they will accept as a patient and are less likely to accept clients who they view "high risk."

Access to prenatal care was a priority concern of the 2005 needs assessment team. The data are still being reviewed and systems of care for obstetrical services are being monitored.

c. Plan for the Coming Year

The MCH Program will continue to monitor access to prenatal care services in light growing concerns about the trend toward fewer women receiving early prenatal care services.

The Title V Program will continue to partner with several agencies and organizations that promote early prenatal care. These included the March of Dimes, Healthy Mothers/Healthy Babies Coalition, the Maryland Commission to Prevent Infant Mortality, and State Medical Professional associations. CMCH was a co-sponsor of the March of Dimes Prematurity Summit held in November 2004.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of children aged 0-72 months screened for lead poisoning/exposure by blood testing*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15	16	17	18	19
Annual Indicator	17.4	17.9	18.2	17.5	17.5
Numerator	74516	76742	79507	76721	76721
Denominator	427939	427939	436817	437968	437968
Is the Data Provisional or Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	20	20	20	20

Notes - 2002

Source: Maryland Department of Enviroment Blood Lead Surveillance Report 2001. Data is for the calendar year. Data for 2002 will be available in late Fall 2003.

Notes - 2003

Source: 2003 Annual Surveillance Report, Maryland Childhood Lead Registry, Maryland Department of the Environment. Data for 2004 is not available.

Notes - 2004

Source: Data is not available for 2004.

a. Last Year's Accomplishments

Childhood lead poisoning prevention continued as a high priority area for Maryland in 2004. The former Governor's July 2000 Initiative on Lead Poisoning Prevention encouraged the coordination of three major agencies - DHMH, the Maryland Department of Environment (MDE), and the Maryland Department of Housing and Community Development(DHCD), and Baltimore City in the assessment, planning and implementation of primary and secondary efforts to reduce childhood lead poisoning.

MDE continued to manage the state's Lead Surveillance System. Surveillance System data for 2004 indicate that 18.2% of Maryland children under age six were screened for lead poisoning/exposure by blood lead testing. Lead Survevillance data for 2004 indicate that testing increased statewide especially at ages 1 and 2 -- 33.8% of one year olds and 24% of two year olds were tested.

CMCH continued to expend funding for State and local lead poisoning prevention activities. Supplemental funding was awarded to local health departments for proposals designed to test the Targeting Plan which is a predictive model. Local Health Departments have traditionally provided outreach through various maternal and child health venues (e.g, nurse home visiting, WIC, and lead outreach/education). Title V funds also continued to support the Baltimore City Health Department's Childhood Lead Paint Poisoning Prevention Project, supporting outreach, community education, case management of children with elevated blood lead levels. This funding also enabled the Coalition to End Childhood Lead Poisoning to provide lead poisoning prevention awareness and case management activities in Baltimore City.

The Maryland Targeting Plan for Childhood Blood Lead Poisoning Plan serves as a basis for legislation passed by the Maryland General Assembly in 2000, HB1221 which enforces blood lead testing of all children ages 12 and 24 months residing in zipcodes deemed ‘at-risk' in Maryland according to the Maryland Targeting Plan. More recent legislation passed by the Maryland General Assembly (HB 819) requires that parents/guardians of children living in areas designated as ‘at-risk' for lead poisoning, must provide documentation from a health care provider certifying that the child has undergone blood testing for lead poisoning. This law also requires health care providers caring for children in areas designated as ‘at-risk' for lead poisoning, as determined by the Maryland Targeting Plan, to administer a blood test for lead poisoning of children at 12 month and 24 month visit.

In 2004, CMCH worked with the University of Maryland, Baltimore County to update the state's lead targeting plan. The new resulted in the CMCH reallocation of limited funds to areas of greater need as well as first time resources to two newly identified counties at risk as well as numerous other census tracts/zip codes.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Implement a statewide plan to eliminate elevated blood lead levels in children by 2010				X
2. Promote blood lead testing through outreach and education to providers and families			X	
3. Passage of legislation mandating blood lead testing at certain ages and at school entry				X
4. Monitor blood lead testing surveillance data collected by the Maryland Department of the Environment				X
5. Fund local health department based initiatives to improve blood lead testing rates			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CMCH is responsible for and has directed efforts towards implementation of HB819. These activities, to date, have included outreach and education to families, health care providers, child care providers, school health personnel, and early childhood programs. The Childhood Lead Screening Program within MCH has recently completed documents necessary for implementation of HB 819. These include a DHMH Blood Lead Test certificate, a resource and referral sheet, and a frequently asked questions brochure. These materials are being distributed to local health departments and to schools in cooperation with the Maryland State Department of Education. Input has been sought from all local jurisdictions regarding appropriate implementation strategies.

The MCH nurse responsible for managing childhood lead issues retired at the end of FY 2004. Because of a state hiring freeze, this position was not be filled. A senior MCH nurse consultant in CMCH began work with the Lead Screening Program during FY 2005.

c. Plan for the Coming Year

Childhood lead poisoning remains a serious threat to the health of children in Maryland. MCH Program plans for FY 2006 include the continued provision of funding to promote lead awareness and blood lead testing through outreach and education in local health departments. Work will revolve around the implementation of HB 819 referenced earlier in this document.

CMCH will continue to address lead issues by partnering with other agencies through various Councils and Workgroups. CMCH is represented on the Governor's Commission on Lead and is actively involved on its Health Subcommittee. CMCH will continue to attend monthly meetings of the Baltimore City Health Commissioner's Lead Stat Group to keep abreast of lead activities and trends in the City. CMCH will also attend monthly meetings of the statewide Lead Partnership to review outreach and education needs to improve lead awareness. Finally, CMCH participates on the Interagnecy Committee on Lead Data which is chaired by the Department of the Environment and meets periodically to address data needs and resources.

This measure was eliminated as one of the state's Title V priorities. The Title V Program will continue to play an active role in eliminating lead poisoning among young children in Maryland. CMCH will continue to partner with other state agencies and community based groups to implement the state's 2010 Plan for Eliminating Elevated Blood Lead Levels among Maryland

children.

State Performance Measure 2: *Percent of women enrolled in the Medical Assistance Family Planning Waiver Program who used at least one service during the state fiscal year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				25	25
Annual Indicator			23.3	24.2	26.1
Numerator			14624	15961	18096
Denominator			62730	66053	69451
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	27	28	29	30	31

Notes - 2002

Source: Maryland Vital Statistics Administration. Data is for Federal Fiscal Year 2002. Data for the previous years is not available.

a. Last Year's Accomplishments

The Maryland Medical Assistance Family Planning Program provides family planning related service coverage under a federal waiver for women who lose Medicaid coverage following their pregnancy-related period of eligibility (within two months of delivery). The Waiver's goal is to increase access to family planning services for low-income women. Access to family planning services improves the wellness of women and influences positive birth outcomes. Since family planning services have been documented to decrease unintended pregnancies and improve birth outcomes, this measure was selected as a new performance measure in 2001 as a means of monitoring unintended pregnancy and access to family planning services. Title V's intent is to promote family planning as a primary prevention strategy for reducing infant mortality and other negative outcomes.

Women eligible for the Family Planning Waiver Program are covered for a limited package of health services. The services covered include office medical visits for family planning purposes; tubal ligation; contraceptive devices and supplies; laboratory tests related to family planning visits, including PAP tests and STD screening; and voluntary and confidential HIV testing. There are no co-payments for services covered under this program. Medical, fertility and abortion services are excluded.

The Waiver Program began enrolling recipients in November 1994. In federal fiscal year (FFY) 2004, Maryland's Medicaid Program received approval to extend the waiver. The length of

automatic program eligibility was decreased from five years to two years. In addition, the Program is required to ensure that Waiver Program enrollees have access to primary care services. All clients in the Maryland Medical Assistance Family Planning Program receive information about community health centers for primary care services. The community health centers accept the Family Planning Waiver card and also provide primary care services on a sliding fee basis.

Between state fiscal years (SFY) 2003 and 2004, the number of women enrolled in the Waiver Program increased from 66,053 to 69,451. In addition, the percentage of women enrolled who used their Waiver card for services rose slightly from 24.2% to 26.1%. Although some progress has been made, low use rates continue to plague the Program. Anecdotally, local health department-based family planning personnel continue to indicate that many women are not aware of their eligibility for services and therefore may not access services.

Because of the low rate of use, the Medicaid Program instituted additional outreach and education efforts to increase utilization. A letter and brochure explaining the Program is now mailed with each card along with a Title X Maryland Family Planning Program brochure. Title X clinic providers served more than 75,000 low-income women in 2004. These providers also screened clients for Waiver eligibility.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund family planning and reproductive health clinical services in every jurisdiction in the state	X			
2. Coverage of family planning services for eligible low-income women the Medicaid Family Planning Waiver Program		X		
3. Screen and refer women in family planning clinics to primary care services including community health centers		X		
4. Provide outreach and education to promote family planning and Medicaid Family Planning Waiver Program		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the current fiscal year, the Maryland Family Planning Program has continued to work with the Medical Assistance Program to implement strategies for improving the utilization of family planning services by women enrolled in the Family Planning Waiver Program. In FY 2005, all Title X family planning providers were required to report on the numbers of Waiver clients screened. Letters and brochures accompanying the distribution of the Waiver cards spelled out benefits and eligibility requirements. These materials explained that there are no co-pays and that women are free to use any provider who will accept the card as payment in full. A toll free number was provided for recipients with questions or for those wishing a referral.

c. Plan for the Coming Year

Efforts will continue in 2006 to promote wider use of the Waiver Program. Title X providers will be asked to report on the number of women with the card accessing services. Family Planning Program staff members will continue to collaborate with Medicaid staff members to educate providers about the benefits of the Waiver Program through regional meetings. Additionally, Family Planning administrators and clinicians will offer consultation to community health centers in an effort to increase awareness about the Waiver Program and support clinical services.

This measure is being deleted. In FY 2006, the performance measure that focuses on the state's unintended pregnancy rate as measured by the PRAMS Survey will be subsituted.

State Performance Measure 3: *Asthma mortality rate (per 1,000,000) among children aged 1 - 14*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.0	4.0	4.0	4.0	4.0
Annual Indicator	4.7	3.7	2.8	4.7	4.7
Numerator	5	4	3	5	5
Denominator	1067199	1070790	1073389	1069891	1069891
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.7	4.7	4.7	4.7	4.7

Notes - 2002

Source: Maryland Vital Statistics Administration. Data is for the calendar year.

Notes - 2003

Source: Maryland Vital Statistics Report, 2002. Data for 2003 is not available.

a. Last Year's Accomplishments

The Maryland Legislature mandated establishment of the Maryland Asthma Control Program in 2002. The Program was charged with developing a statewide asthma surveillance system and an asthma control program. Maryland has been the recipient of a CDC funded asthma grant since 2001. These funds have been used to support asthma activities in Maryland including the hiring of a part time asthma administrator in 2004. Administrative responsibity for asthma largely rests with the Center for Maternal and Child Health.

The final Maryland Ten-Year Asthma Plan was submitted to the Secretary of Health and Mental Hygiene for approval in FY 2004. The Maryland Asthma Planning Task Force was disbanded

and replaced by a statewide asthma coalition to oversee implementation of Task Force recommendations. CMCH submitted an application to the CDC for funding to implement sections of the10 year asthma control plan.

Surveillance activities continued and a second asthma surveillance report was published in 2004, Asthma in Maryland 2003. Support for asthma surveillance was largely provided through a contract with the University of Maryland School of Medicine with CDC funding. An asthma module was added to the BRFSS in 2002 and the data will be available in 2004.

Several objectives and strategies of the "Maryland Asthma Plan" were initiated in 2004. During World Asthma Day in May 2004, CMCH displayed outreach and education materials and hosted the University of Maryland's Breathmobile. An Asthma Action Plan has been developed for use by families and providers to ensure that appropriate actions are taken to control asthma. Five health care provider professional organizations developed and implemented educational activities to improve adherence to NHLBI Guidelines. Finally, CMCH developed the Maryland Asthma Resource Guide. This Guide will be used to assist families, health care providers, and public health professionals to realize the available asthma resources across the nation, throughout Maryland and within local jurisdictions.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct asthma surveillance including publication of an annual surveillance report				X
2. Implement components of a statewide asthma plan for Maryland		X	X	X
3. Chair and provide staff support for a statewide Asthma Coalition				X
4. Fund local health department based and community based asthma education and outreach initiatives			X	
5. Promote and support regional and local asthma coalition activities				X
6. Chair and provide staff support for the Governor's Children's Environmental Health and Protection Advisory Council				
7.				
8.				
9.				
10.				

b. Current Activities

During FY 2005, the Maryland Asthma Control Program continued to implement select interventions to reduce asthma morbidity and mortality. The third edition of the Asthma Surveillance Report was completed. Chapters were added to address work-related asthma, asthma among Medicaid enrollees, and racial/ethnic disparities in asthma morbidity and mortality. In addition, the chapter on asthma prevalence was expanded to include additional information about asthma symptoms and treatment among adults.

The program is supporting and monitoring several initiatives to educate providers, parents/patients and the public about asthma prevalence, treatment and best practices management. For example, the Program supports the University of Maryland Children's Hospital Breathmobile. The Breathmobile is a mobile asthma clinic that provides asthma care in

Baltimore City, Prince George's county schools and Head Start sites. The Breathmobile staff also provides case management and educates caregivers.

Asthma continues to disproportionately affect African American children in Maryland, particularly those living in Baltimore City. CDC funds are being distributed to the University of Maryland School of Medicine to provide asthma education activities to reduce this disparity. When patients present at the emergency department because of an asthma episode, asthma education is conducted. An asthma educator ensures that the family understands the instructions given by the health care provider, especially instructions related to treatment and triggers, and assists the family in accessing services to ensure continuity of care.

A project in Montgomery County is being funded to increase the knowledge of low income Latino parents of asthmatic regarding proper treatment and management; increase awareness and use of pediatric clinical services; and develop culturally and linguistically appropriate asthma managment interventions.

The Title V Program is continuing to support and strengthen asthma coordination and collaboration. Four local health departments are receving funding to develop and/or sustain local asthma coalitions. The Maryland Asthma Coalition continues to meet quarterly.

c. Plan for the Coming Year

Many of the activities currently being implemented will be continued in 2006. Asthma surveillance will continue. BRFSS data from the childhood asthma module will be included in the 2006 surveillance report. The Program also also anticipates participating in the BRFSS Asthma Call Back Survey. This Survey will provide data on the frequency and severity of asthma episodes, treatment and management practicies, environmental controls and exposure, cost, etc. Findings will also be incorporated into the 2006 report.

An Asthma Display Board is being designed and will include facts about asthma, the signs and symptoms, and encourage the use of an Asthma Action Plan. The Display will be available for educational events throughout the state.

On October1, 2005, the Children's Environmental Health and Protection Advisory Council is hosting a regional Children's Environmental Health Conference in Baltimore. Asthma will discussed as an important indicator for children's environmental health and an area for potential collaboration.

State Performance Measure 4: *Percentage of local jurisdictions addressing the issue of respite for families of CSHCN*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25	50	60	75	75
Annual Indicator	25.0	62.5	66.7	70.8	66.7
Numerator					

	6	15	16	17	16
Denominator	24	24	24	24	24
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75

Notes - 2002

In FY 2002 , 15 of 24 jurisdictions provided direct respite services and one engaged in a respite provider capacity building project. In FY 2003, 15 jurisdictions provided direct respite services and 2 began needs assessment.

a. Last Year's Accomplishments

Respite care continues to be a significant need for Maryland families of CYSHCN. The issue of respite comes up frequently in needs assessment activities at the local level, and according to the National Survey of CSHCN, about 22% of Maryland families who reported needing respite in the 12 months prior to the survey indicated that they did not receive all of the respite care that was needed. Respite was identified as the 2nd highest area of unmet need in the survey.

Respite care funds were awarded to 16 out of 24 local jurisdictions in FY04. With some unexpected funds in our budget, we were also able to provide supplemental respite grants to 10 of these jurisdictions. Many of the local jurisdictions were successful in collaborating with families and community agencies to develop creative and cost-effective respite initiatives, such as a Saturday drop-off program for children with severe or profound disabilities and partnership with the local Departments of Parks and Recreation to provide specialized summer day camp opportunities for CYSHCN. Parent feedback has generally been very positive. As one parent wrote, "The whole family benefited. Mom and Dad have a safe place for [our daughter] and a break from her care. We also get some one-on-one time with her brother."

In FY04, the total number of children/families served with respite monies granted to the local jurisdictions was 797. Of those served, 280 received "respite hours" and 517 participated in some type of camp activity. Funding was also given in FY04 to the Maryland Alliance of PKU Families to send 25 children to PKU camp. This is a family camp and a total of 60 individuals attended. Respite care funds this past year served children with a variety of special health care needs, although children with developmental and behavioral problems tended to be more highly represented. The majority of jurisdictions had waiting lists for respite funds.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide grants to local health departments to support a variety of respite activities for CYSHCN in their communities.		**X**		**X**
2. Provide grants to disease specific organizations for camp for CYSHCN.		**X**		
3. Serve on the Governor's Caregiver Support Coordinating Council and partipate in Real Choice Respite Grant for Children activities.				**X**
4. Provide expertise for other respite initiatives in the state.				**X**

5. Communicate with jurisdictions currently not supporting respite activities around feasibility of respite initiatives.				X
6. Informally assess need for greater availability of respite services for children with "medical" diagnoses such as cystic fibrosis.				X
7.				
8.				
9.				
10.				

b. Current Activities

In FY05, 16 local jurisdictions were again awarded respite funds to support a variety of respite care activities.

The OGCSHCN's Regional Resource Coordinator, a parent of a child with special health care needs, is the Department of Health and Mental Hygiene's designee on the Governor's Caregiver Support Coordinating Council. She is currently working with this council on the Real Choice Respite Grant for Children. This grant comes from Maryland Medicaid with the goal of developing a respite care model in the state for Medicaid. The population of children with severe emotional disturbance (SED) is being used as the focus of this project. A survey of respite providers in Maryland has been completed, identifying the capacity in the state to provide respite services to children with SED. The council is currently developing a family survey to document information such as need for respite services, how families access these services currently, and barriers in the system.

c. Plan for the Coming Year

Respite funding has been awarded to 15 out of 24 local jurisdictions thus far for FY06. In the coming year, we plan to communicate with those jurisdictions who are currently not accessing respite funds from the OGCSHCN about the availability of funds for this purpose. Some jurisdictions have lacked the administrative capacity to properly administer these funds in the past, but the situation in these jurisdictions may have changed. We also hope that the success stories of other jurisdictions may be built upon. In addition, we hope to have a dialogue with the jurisdictions currently receiving funds about whether they perceive the need to increase the numbers of children served with more traditional "medical" diagnoses such as diabetes and cystic fibrosis.

State Performance Measure 5: *Percent of women who do not smoke during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90%	90	90	90	90

Annual Indicator	90.2	91.1	91.9	92.2	92.2
Numerator	66949	66664	67338	69044	69044
Denominator	74226	73152	73250	74865	74865
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	93	93.1	93.2	93.3	93.4

Notes - 2002

Source: Maryland Vital Statistics Administration. Data is for the calendar year. 2002 data will be available in Fall 2003. Maryland PRAMS data will also soon be available for monitoring this measure.

Notes - 2003

Source: Maryland Vital Statistics Administration. Data for 2003 is not yet available.

Notes - 2004

Source: Maryland Vital Statisics Administration. Data is not yet available for 2004.

a. Last Year's Accomplishments

The percentage of pregnant women reporting smoking during pregnancy has been steadily declining in Maryland. Maryland birth certificate data for 2002 indicate that only 8% of pregnant women in Maryland reported smoking during pregnancy. However, data derived from the Maryland Prenatal Risk Assessment Database, indicate that low-income pregnant women were more likely than pregnant women in the general population to smoke prenatally. This database reported that 23% of pregnant women referred to local health departments through the Prenatal Risk Assessment process were tobacco users in FY 2004. (The Prenatal Risk Assessment Form is completed by health providers serving Medical Assistance and low income women in the State. The database includes approximately 22% of the State's pregnant women).

The Maryland Center for of Health Promotion, Education, and Tobacco Use Prevention has lead responsibility for smoking cessation activities in DHMH. This Center administers the Smoking Cessation in Pregnancy (SCIP) Program. SCIP is a multi-component program designed to help pregnant women stop smoking. It is a nurse driven intervention for patients receiving preconception and prenatal care services from local health departments or Medicaid managed care health providers. Pregnant smokers meet with public health nurses who counsel them to quit or reduce tobacco use. Along with one-on-one counseling, participants receive self-help materials in the form of a manual and a "Quit Kit." Cigarette Restitution Fund (CRF) grants awarded to each jurisdiction were also used to support this initiative.

Local health departments continued to promote smoking cessations during pregnancy as a part of preconception health counseling during family planning visits in FY 2004. Local health departments also continued to partner with groups such as the March of Dimes to educate pregnant women about the health risks linked to smoking during pregnancy. In 2004, CMCH continued collaborating with multiple intra and inter-agency groups, private providers, community-based organizations and the American College of Obstetricians and Gynecologists to develop a statewide plan and initiative to reduce smoking during pregnancy.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Administer the Smoking Cessation in Pregnancy (SCIP) Program in local health departmetns		X		
2. Promote smoking cessation during preconception heath counseling sessions		X		
3. Collaborate with the American College of OB/GYNs and others to develop a plan to reduce smoking prior to and during pregnancy				X
4. Monitor smoking during pregnancy through several state databases including Vital Statistics and the Pregnatal Risk Assessment Database				X
5. Support smoking cessation programs through the Cigarette Restitution Fund initiatives		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Anecdotally, the 2005 Needs Assessment documented that increasing percentages of pregnant women are reportedly smoking in some jurisdictions. This finding will be further investigated in the next fiscal year.

Other ongoing activities, including the Smoking Cessation in Pregnancy Program continued in 2005.

c. Plan for the Coming Year

Ongoing activities will continue in 2006. The CMCH, including the Office of Women's Health, plans to work more closely with the Cigarette Restitution Fund Program to promote smoking cessation among women, particularly during pregnancy.

This measure has been eliminated as a state performance beginining in FY 2006. A measure that examines alcohol use during pregnancy has been substituted.

State Performance Measure 6: *Congenital syphilis rate in Maryland*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40	40	40	40	40
Annual Indicator	21.6	6.8	21.8	16.5	13.3
Numerator	16	5	16	12	10

Denominator	74226	73152	73250	72732	75000
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.3	13.3	13.3	13.3	13.3

Notes - 2002

Source: Maryland Division of Sexually Transmitted Diseases. Data is for the calendar year. The number of live births for 2002 is preliminary.

a. Last Year's Accomplishments

Lowering the congenital syphilis rate was chosen as a State performance measure when the number of presumptive congenital syphilis cases in Maryland rose to an all time high of 60 in 1997. By 2001, the number of cases had declined to 5 and a rate of 6.8 per 100,000 live births. The rate decrease was largely attributed to increased provider education and outreach to at risk populations such as substance abusers and inmates of correctional facilities. A Congenital Syphilis Work Group, comprised of representatives from CMCH, local health departments, and the STD Control Program, was convened. This Work Group developed protocols for case management and tracking of women testing positive for syphilis. In addition, the Baltimore City Health Commissioner issued an order mandating that syphilis screening occur early in the first and third trimesters and at delivery.

Between 2001 and 2002, the number of reported cases once again began to rise, increasing in number from 5 to 16 cases. As a result, quality assurance efforts were expanded by identifying congenital syphilis cases as a priority for fetal and infant mortality review teams in FY 2003. FIMR programs were asked to review every case of congenital syphilis identified in their jurisdiction. Seven jurisdictions reviewed 16 cases, ten of which occurred in Baltimore City. FIMR coordinators who had a case of congenital syphilis in their county were invited to participate in a FIMR workshop on congenital syphilis held in May 2003. This workshop included basic information about congenital syphilis, and provided assistance to local FIMRs on how to prepare and review a congenital syphilis case.

New regulations were issued in 2003 required physicians to test for syphilis at or near 28 weeks of gestation. In 2004, the number of cases declined to 10 and the congenital syphilis rate stood at 13.3 per 100,000 births.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor trends in the incidence and prevalence of congenital syphilis				**X**
2. Collaborate with the state's Sexually Transmitted Disease Program and others to reduce congenital syphilis rates				**X**
3. Review congenital syphilis cases as part of the state's FIMR process				**X**
4. Educate health providers about timely syphilis and STD screening during pregnancy			**X**	**X**
5. Mandate that syphilis screening occur at certain intervals during pregnancy				**X**

6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY 2005, the Title V Program continues to partner with the STD Control Program, the Baltimore City Health Department, the criminal justice system, the CDC, health care provider groups and others to further reduce the number of congenital syphilis cases. The MCH Program is awaiting findings from the FIMR Congential Syphilis Report to determine further strategies needed to reduce this preventable disease.

c. Plan for the Coming Year

The number of congenital syphilis cases as a concern and will continue to be monitored by the Title V Program. However, following completion of the Title V needs assessment, this measure will no longer be tracked as a Title V performance measure.

State Performance Measure 7: *Percent of fetal, infant and child deaths reviewed by local teams*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	20	20%	22%	24	27
Annual Indicator	13.3	27.1	27.1	33.3	33.3
Numerator	205	432	421	526	526
Denominator	1541	1592	1556	1581	1581
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	40	45	50	55

Notes - 2002

Source: Numerator obtained from data collected from FIMR and CFR Committees in Maryland by the Center for Maternal and Child Health. Denominator includes fetal, infant and child deaths.

Notes - 2003

Source: Child Fatality Review and Fetal and Infant Mortality Review Reports for 2002. 2003 data is not yet available.

a. Last Year's Accomplishments

In 2003, there were 1,581 fetal, infant and child deaths in Maryland. Child Fatality Review is a Maryland mandate. In FY 2004, local teams reviewed 33% of child deaths with the purpose of identifying changes at the systems level to prevent future deaths. Activities were carried out by state and local level CFR teams and local level FIMR teams.

In 2004, Maryland's 18 local FIMR programs identified 1,241 cases of fetal or infant death through such sources as birth and death certificates, county vital statistics, Healthy Start home visiting forms and hospital records. One hundred eighty eight (188) cases of fetal or infant death were chosen for a full committee case review. Additionally, local FIMRs were successful in completing 119 maternal interviews representing 63% of the total cases reviewed. The special focus for last year was congenital syphilis and FIMR programs were asked to review every case of congenital syphilis identified in their jurisdiction. A total of 16 cases of congenital syphilis were reported in 2002 and all were reviewed.

During FY 2004, Title V continued to support a contract with the state medical society, MedChi to provide technical assistance to local FIMRs. MedChi in collaboration with CMCH produced and distributed a bi-monthly newsletter, convened a statewide FIMR Advisory group, and held three trainings for FIMR coordinators. One training, New Directions for FIMR in Maryland, addressed data gathering, planning and evaluation of FIMR programs and included a self -- assessment of preparedness for local community action among FIMRs. FIMR findings were grouped into twelve common themes. Prenatal care, provider issues and care coordination were the themes with the greatest number of findings and recommendations. FIMRs used their findings and recommendations as a basis for action.

Local child fatality review teams reviewed 266 cases in 2004. The Office of the Chief Medical Examiner studies deaths that are considered suddent and unexpected. These cases and information concerning the death are referred to the local CFR Team. Although, CFR is an unfunded mandate, by the end of FY 2004, 23 of the state's 24 jurisdictions had active CFR teams.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct FIMR and CFR processes in every jurisdiction				X
2. Support FIMR activities through the Improved Pregnancy Outcome Program and Crenshaw Perinatal Health Initiative				X
3. Provide support to the State's Child Fatality Review Team as mandated				X
4. Develop and implement recommendations and systems changes based on findings through the mortality review processes		X	X	X
5. Publish annual reports on fetal, infant and child deaths in Maryland				X
6. Provide technical assistance for state and local maternal, fetal, infant and child fatality review processes				X
7.				
8.				
9.				
10.				

b. Current Activities

During FY 2005, local FIMR teams have been asked to review all fetal and infant death cases of less than 1,500 grams (VLBW) occurring at non-tertiary care facilities. Additionally, local FIMR programs identified other issues to be investigated as a result of local reviews. These issues include domestic violence, racial disparities, smoking and substance abuse, undocumented immigrants, bereavement support, preterm labor and kick count, safe sleeping, undocumented immigrants and hospital protocols for parents with a loss.

The State CFR Team is addressing several priorities in 2005. These include providing training for local teams, examining disparities in child deaths, developing policy recommendations to reduce child deaths, and developing protocols to address near fatalities as required by law. The State is developing an OCME managed uniform online data collection system for entering and retrieving child death data. As a result, local teams will be able to expedite the CFR process by online reporting gathering of data and reporting of review results. Title V funding is being used to hire two graduate students to develop this online reporting system.

c. Plan for the Coming Year

The Center for Maternal and Child Health is committed to continuing to provide leadership for FIMR and CFR activities in FY 2006. This leadership is exemplified by CMCH allocation of Title V dollars to the State mandated, but largely unfunded CFR process. These federal dollars will continue to be combined with funds for FIMR and maternal mortality review activities under a contract with the State Medical Society. Because of the link between FIMR, CFR, domestic violence, and child abuse, one intent of this consolidation is to identify children and families at risk so that comprehensive preventive strategies can be developed.

The CFR Team plans to survey local teams to determine any additional technical assistance needs. LBW and VLBW births will remain as a priority focus area for FY 2006. In addition, FIMR staff and consultants have preliminarily discussed identifying racially based perinatal disparities as a second focus area.

This measure will no longer continue as a state Title V Performance Measure.

State Performance Measure 9: *The rate of deaths to children aged 1-4 caused by sickle cell disease*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4	4	4	4	4
Annual Indicator	0.0	0.0	0.0	0.0	0.3
Numerator	0	0	0	0	1
Denominator	214	239	285	280	286
Is the Data					

Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4	4	4	4	4

Notes - 2003

This is the correct data . There were 280 children with sickle cell disease between the ages of 1 and 4 in FY 03 and none of them died. So the death rate is 0 (zero). We have been very fortunate in Maryland in being able to dramatically reduce deaths from sickle cell disease in young children. However, there was one death in FY 04, so the numerator isn't always going to be 0 and the death rate isn't always going to be 0.

Notes - 2004

A new performance measure is not formulated because all deaths from sickle cell disease related causes cannot be prevented, no matter how good your program is. Infections preventable with penicillin prophylaxis or vaccines can be prevented almost entirely with a very aggressive follow up program like ours. However, infections with resistant or unusual organisms are not preventable, although they can be kept to a minimum by parent education, and by assuring that each child has regular primary and subspecialty care and that providers use standard of care protocols. In 1997, there were several deaths during an upsurge in penicillin resistant organisms. At present, we may be seeing an increase in infection by an unusual pathogen, not grown well in culture. There may be additional deaths of this type. These deaths are not due to poor performance in the program. Also, deaths from strokes can reduced, but not entirely prevented, by parent education, regular primary and subspecialty care, transcranial Doppler to identify high risk patients and transfusion protocols for at risk patients.

a. Last Year's Accomplishments

The sickle cell disease related mortality rate for children aged 1-4 in Maryland was 0.3% in FY 04, with one death among the 286 children with sickle cell disease in this age group. This is the first child in this age group to die from sickle cell disease related causes since 1997. This was a confusing case. The child presented with fever and a septic appearance at 19 months of age and received a full course of IV antibiotics as an inpatient. No organism was identified. The child was discharged clinically well and resumed prophylactic penicillin. On the third day after discharge, the child presented again with fever and a septic appearance, went rapidly downhill and expired, despite broad spectrum IV antibiotics and full ICU support. There was a similar case in a much older child in Washington, DC within a few weeks. No organism was ever identified in either case. Fortunately, there have been no additional cases.

The OGCSHCN continues to provide newborn screening follow up and case management. In FY04, there were 1,446 patients with significant sickling disorders in the registry. Grant monies also support the hematology clinic infrastructure. In FY 04, 993 patients were seen at Johns Hopkins, 83 were seen at University of Maryland, 256 at Sinai Hospital of Baltimore and 995 at Children's National Medical Center (DC). Some patients were seen at more than one center. The OGCSHCN supports a Transition Clinic for adolescents with sickle cell disease at Johns Hopkins. This clinic has succeeded in attracting adolescents and young adults from all institutions, especially the University of Maryland and Sinai Hospital of Baltimore. A total of 18 young adults were transitioned to the adult service in the last year.

The Department of Health and Mental Hygiene offers offer free carrier screening to older children and adults. A total of 8,223 patients were screened in FY2004. The Chesapeake Community Sickle Cell Disease Support Group, supported by the Baltimore RH Laboratory in partnership with the OGCSHCN, held a series of screenings in local high schools. A total of

119 patients were screened.

The Sickle Cell Disease Clinic at Johns Hopkins Hospital worked with the OGCSHCN to revive some of the special activities that had been supported by the OGCSHCN for this population in the past. Support group meetings were held at Johns Hopkins every other month and attracted patients form all institutions. A picnic was held in September (Sickle Cell Disease month) 2004. Approximately 150 people from all institutions attended. This is being planned as an annual event. The Chesapeake Community Sickle Cell Disease Support Group organized a walkathon to raise consciousness in the community. Approximately 125 people attended and again participants came from all the institutions.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify affected children through newborn screening	X		X	
2. Ensure diagnostic evaluation and linkage with hematologist		X		
3. Provide home visits and parent education	X	X		
4. Provide case management facilitated by extensive data collection from PCP and specialists		X		X
5. Support hematology clinic infrastructure				X
6. Provide educational materials to families and consultation to families and providers as needed		X		
7. Support recreational and educational activities for children with sickle cell disease and their families		X		
8.				
9.				
10.				

b. Current Activities

The OGCSHCN contracted with Pediatrix to perform mutation analysis for the common thalassemic mutations on newborn screening specimens with FSA patterns. This has reduced the false positive rate in this group.

The Sickle Cell Disease Follow-Up Program continues in its current form. The staff in this program helps to ensure appropriate diagnosis and management of Maryland children with sickle cell disease through age 5 years. Children identified through newborn screening are referred for diagnostic evaluation and linked with a hematologist at one of the specialty centers. The program nurse makes a home visit to families of newly diagnosed children for support and education around the important components of care for children with sickle cell disease. Genetic counseling is also provided. The program works with the family, primary care provider, and specialists to ensure that all children receive prophylactic penicillin, appropriate immunizations, and other interventions as needed. This is facilitated by a system of comprehensive data collection from the PCP and specialists established by the program. A health history of every Maryland child with sickle cell disease is maintained by the program up to age 5 years in this database to ensure that there are no gaps in care. The program is able to provide phone consultation to PCPs and families as needed, and the nurse will attend hematology clinic visits to provide further support and education to families requiring this.

The Department continues to offer free carrier screening .The Chesapeake Community Sickle

Cell Disease Support Group continues to offer screening in the high schools. The OGCSHCN continues to support the pediatric hematology clinic infrastructure, including the Transition Clinic, and to partner with support groups to sponsor social activities. Some program educational materials were updated and others are in progress

Both the Johns Hopkins Sickle Cell Disease Support Group and the Chesapeake Community Sickle Cell Disease Support Group are planning their events on an annual basis. However, there has been no progress in reviving a community based support group for sickle cell disease that has serious fund raising capability. Although the National Sickle Cell Disease Association of America moved its headquarters to Maryland, this organization is currently not supporting fledgling groups at the community level. When a more established local group existed, it partnered with the OGCSHCN to sponsor a number of outreach and educational activities for children with sickle cell disease and their families, including a tutoring program, an annual picnic, a holiday party, and a summer camp.

c. Plan for the Coming Year

The OGCSHCN will continue the Sickle Cell Disease Follow-Up Program in its current form for the coming year. The Department will continue to offer free carrier screening. The Chesapeake Community Sickle Cell Disease Support Group intends to continue to offer screening in the high schools. The OGCSHCN will continue to support the clinic infrastructure and partner with support groups to sponsor social activities. We will also continue to search for a community partner interested in organizing a summer camp experience for children with sickle cell disease next summer.

The OGCSHCN will continue to work with Amerigroup (Dr. Ginny Moore) to promulgate the Mid Atlantic Sickle Cell Disease Consortium Guidelines for pediatric sickle cell disease care among MCOs.

The OGCSHCN is extremely concerned because the oldest of our cohort of patients identified through newborn screening are approaching 20 years of age. While we hope to expand the Transition Clinic, there is no system of care for adult sickle cell disease patients that is comparable to the pediatric system. There are very few adult clinics specifically for sickle cell disease patients and the only comprehensive adult clinic is at Johns Hopkins. There is also is no over arching programmatic infrastructure and little support group activity since the death of several of the most socially active adult patients. Dr. Shirley Grant (internal medicine) from Amerigroup will work with the OGCSHCN in the coming year to improve care for adult sickle cell disease patients including, of course, young adults.

E. OTHER PROGRAM ACTIVITIES

MCH Hotline/Children's Resource Line: The MCH/Medicaid Programs operate an 800 number telephone line for MCH outreach, information and referral (1-800-456-8900). This line is located and operated by the Medical Assistance Program and is used to provide information and education about the Medical Assistance Program as well as to refer callers to MCH providers. The Title V Program continues to support the Hotline.

Web Sites: Both the Center for Maternal and Child Health (www.fha.state.md.us/mch) and the Office for Genetics and Children with Special Health Care Needs www.fha.state.md.us/genetics) to provide functional web sites. These web sites include information about all programs funded or provided, as well as information about the Title V program, including linkage to a copy of the complete Title V report for the most recent fiscal year.

Women's Health: An Office of Women's Health was established within CMCH in 2001 with the goal of

promoting wellness for Maryland women throughout the lifespan. Activities of this Office include the publication and dissemination of a reports (e.g., chartbook on the heath status of Maryland women; postpartum depression); promotion of inter and intra-agency coordination on women's health issues, and implementation of a statewide model for integrating preventive health screening into family planning programs.

Childhood Obesity Prevention: The prevention of childhood obesity remains as a MCH priority for 2006. The collaborative partnership begun with the Office of Chronic Diseases in FY 2001 to address obesity through strategic planning, surveillance, provider, education and promotion of public awareness will continue. In May 2002, the MCH program sponsored a statewide meeting of childhood obesity experts and stakeholders to develop recommendations for addressing childhood obesity. The lack of a consistent data source for monitoring obesity was noted. Following the 2002 and in conjunction with the receipt of a CDC grant to address obesity in Maryland, a Childhood Overweight Work Group has been formed. The Title V Program has lead responsibility for the Work Group and is partnering with other agencies and professional groups to implement recommendations developed by the expert panel in 2002. This Work Group is considering holding a statewide planning of experts to review state progress on surveillance and other activities aimed at preventing obesity across the lifespan.

Early Childhood Programs and Mental Health: Mental health related issues were identified as a major unmet need for both women and children during the 2005 needs assessment. As mentioned above, the Office of Women's Health has identified depressive disorders as one of its priority focus areas. Maternal depression, an important risk factor in the development of childhood mental health problems is being examined. The MCH Program continues to be an active participant on the State's Early Childhood Mental Health Steering Committee established in 2001. This Committee's charge is to develop a plan for integrating mental health services into existing early childhood programs.

In March 2003, CMCH applied for and was awarded a MCHB State MCH Early Childhood Comprehensive Systems (ECCS) Grant. Maryland's goal is to develop an Early Childhood Health Strategic Plan. This Plan will ultimately be integrated with plans addressing the other four remaining critical components of early childhood - mental health, parent education, early child care and education, and family support -- to create an Early Childhood Comprehensive Systems Plan for Maryland.

A planning group, known as the ECCS CORE group, has been convened and consists of personnel from the Center for Maternal and Child Health, partners/collaborators involved in developing a previous statewide Early Childhood Action Agenda and key members from groups charged with other early childhood collaborative efforts. This ECCS Core group has met several times to develop Maryland's plan which is projected to be completed in the next fiscal year. A full time Project Director was hired in FY 2005.
Technical assistance has also been sought through MCHB to determine an appropriate methodology for developing an early childhood collaboration model for Maryland given the current status of planning and collaborative efforts. The Core Group identified and recommended partners perceived as critical to the planning and collaboration processes.

Fetal Alcohol Spectrum Disorders (FASD): The 2004 Maryland legislative session introduced legislation related to FASD. Among the legislation considered were a statutory requirement for a FASD Task Force and commitment to a public health education campaign. The public health education campaign was approved, but unfunded. The Task Force legislation was withdrawn because stakeholders agreed to forma a FASD Work Group. CMCH has been a key member of this Work Group. The Work Group is currently developing a strategic plan to guide development of interventions to prevent, identify and treat FASD.

Conferences and Training: The MCH Program: CMCH recognizes the importance of enhancing public

health competency through ongoing training and education. It achieves this activity by providing training opportunities to LHD public health personnel in important MCH domains such as home visiting, school and adolescent health, screenings and surveillance and asthma education. Several conferences are annually supported by the MCH Program. These include the annual reproductive health update, the annual school health institute, an asthma summit, a perinatal health conference, and special technical assistance workshops for local health departments.

Sudden Infant Death Syndrome: Title V monies will continue to support the Maryland SIDS Project at the Center for Infant and Child Loss, University of Maryland School of Medicine. This Center provides SIDS outreach and education as well as counseling to support families experiencing the death of a child.

F. TECHNICAL ASSISTANCE

The state of Maryland is not submitting a technical assistance request at this time. Technical assistance needs may be discussed at the August review meeting with the Maternal and Child Health Bureau.

V. BUDGET NARRATIVE

A. EXPENDITURES

This section describes Title V expenditures for FY 2004 and notes trends and shifts in expenditures over the past several years. During FFY 2004, the majority of the $21,372,400 in Title V -- State partnership funds supported activities at the infrastructure and enabling levels ($15,798,975 or 73.9%). These expenditures met the 30-30-10 budgeting requirement.

Several significant changes have occurred during the time period 1996-2005. First, the State of Maryland through the development of a fiscal data system has been able to monitor expenditures more effectively and efficiently. This has resulted in the expenditure of all funds during the first year of each grant cycle. Therefore, the Federal-State Title V Block Grant Partnership Total is more reflective of the actual dollars awarded and expended in the first year. This change began in FY 1998 and continues. In addition, beginning in FY 2000 the fiscal data system was refined to monitor more effectively funds within the pyramid itself. Periodically, additional refinements have been made to the system. The most recent one occurred in FY 2003 and resulted in greater accuracy in identifying both state and federal fiscal year expenditures.

The first notable shift in funding allocation occurs in FY 1999 with the advent of MCHP making children in families with incomes up to 200% FPL eligible for Medicaid services. Direct expenditures went from 61% to 28% in one year. This continues to decrease as Maryland's Medical Assistance Program assumes greater fiscal role, including covering more CSHCN unique services. The second shift occurred during that same year, with enabling services increasing from 15% in 1998 to 25% in 1999 to a high of 56% in 2000. This service expenditure has been gradually decreasing since 2000, to the current level of 41.5% in 2004. The reason for this dramatic increase was the need for the health care system to absorb the dramatic shift in services. Many local health departments were initially reluctant to turn over all care coordination to the newly formed Managed Care Organizations (MCO). This concern has decreased as MCO case management has been instituted and a formal communication system has been established. Most of the current funding for these services has been in prenatal and early infant home visiting of the families most at risk for poor maternal and birth outcomes. The last shift has occurred as the State Title V Agency has educated and notified local health departments that combined, the majority of Title V dollars should be allocated for population-based services and infrastructure development.

While dialogue began in 2000 during the last Title V Needs Assessment, it wasn't until FY 2002 that a significant shift began to occur. As a percentage of total federal expenditures, population-based services moved from 5% in 2001 to 15.5% in 2004, and infrastructure-based services shifted from 28% in 2001 and to 32.3% in 2004. This resulted in the continual decline of direct service dollars to a new low of 13% in 2002 and an increase in 2003 to 19%. This financial movement was accelerated by the events of 9-11-01 and the sudden and significant increase in bio-terrorism and emergency preparedness. It is the intent of the Title V Agency to evaluate the effectiveness of the allocation in improving health outcomes, particularly as it relates to enabling services.

B. BUDGET

The Maternal and Child Health Program budgets and functions reflect an evolving public health responsibility that complements and enhances the current health delivery system, recognizes recent legislative changes in health and mandated public health functions, the uniqueness of the populations being served, and emerging research and standards of care affecting the health status of MCH populations. Maryland's Title V budget for FY 2006 totals $21,372,400 including $12,367,885 in federal funds and $9,275,914 in state funds.

Maryland continues to allocate Maternal and Child Health Block Grant funds using criteria that include: (1) MCH priority needs based on statewide and community assessments, (2) local health department fiscal shortfalls within the identified core categories, (3) poverty rates and estimated size

of the maternal and child (birth-21 years of age) population, (4) performance measures and outcome measures and (5) the availability of other funding sources. An example of this is the MCHP expansion which enabled funds to be reallocated from direct services for CSHCN to other population groups ineligible for MCHP. Funds may be reallocated throughout the year when unexpected needs are identified. (Budgets are developed two years prior to authorized spending. For example during the summer of 2004, the MCH Budgets for FY 2006 were developed. During the 2005 Legislative Session, the FY 2006 budget was approved).

Throughout the development and subsequent expenditure of the MCH budget, the grant is fiscally and programmatically monitored to ensure that the funding levels adhere to the "30-30-10" Title V requirement. For FFY 2005, it is proposed that funding for each Title V population will be distributed accordingly: Preventive and primary care for children -- 31%, CSHCN --31% and Administration -- 8%. The other category at 30% refers to maternal and infant health population. In addition, throughout the two-year process, but particularly during the budget development and the revision phase (based on legislative authorized budget), the MCH Offices evaluate the MCH Service Pyramid fiscal allocation to ensure that it reflects the spirit and intent of MCHB. For this FY 2006 application, the budget allocation is based on budgets developed during the summer of 2004 with slight revisions as a result of the legislative process.

The FFY 2006 budget also reflects a shift in funding from preventive and primary care services to children to services for mothers and infants as more local health departments allocated resources for improving declining maternal and birth outcomes. This effort has expanded to include prevention of low birth weight, particularly very low birth weight, as well as continuing to maintain the emphasis on preventing infant mortality. It is believed that through focusing on the risk factors that influence infant mortality, a more positive outcome will be realized.

Throughout the year, quarterly meetings are held between the MCH Offices and the Budget Personnel to determine current expenditure levels and expected expenditure for the remainder of the year. It is during these meetings that budget shortfalls and funds to be reallocated are identified. Throughout the year all contracts including LHD grants are tracked through the procurement process and subsequently monitored for appropriate and timely expenditures, and adherence to DHMH fiscal procedures.

The State share in MCH services is considerable, and more than meet the requirements for the State match. State appropriations dedicated to MCH related activities include early intervention services, immunizations, mental health and family planning services. Federal sources of MCH related dollars other than the block grant include early intervention, Part C; Centers for Disease Control and Prevention (immunizations and the public health infrastructure); abstinence education; family planning; WIC; HIV/AIDS; and SSDI (community assessments, enhancing data and epidemiological capacity). Maryland meets the maintenance of effort requirement of Sec. 505 (a)(4).

This section contains a budget narrative which describes Maryland's proposed expenditure plan for the coming fiscal year. For FFY 2006, federal Title V funds in the amount of $6,383,946 will be allocated for programs and services for women and infants. These funds will be administered through the Maternal and Perinatal Health Program and will support infrastructure level activities, through the Improved Pregnancy Outcome Program (IPO) and the Crenshaw Perinatal Health Initiative, to improve pregnancy and birth outcomes. IPO funds are provided to each local health department to support FIMR and other activities. Crenshaw funds are competitively awarded to local health departments to support innovative strategies. Funds will also partially support promotion of breastfeeding, education about perinatal depression, and support for identification and prevention of fetal alcohol spectrum disorders (FASD).

Title V will also support local health department based home visiting and care coordination services for pregnant women and infants as well as other activities aimed at improving the health of pregnant women and infants including standards development, quality assurance, health promotion and outreach. Preventive and primary care services for pregnant women and children are administered by

the Center for Maternal and Child Health. In addition, newborn screening activities are carried out by the Office for Genetics and CSHCN. Newborn Screening includes two major programs. The Newborn Screening Program screens newborns for 32 disorders that may cause mental retardation and/or serious medical problems unless treated soon after birth. The Universal Infant Hearing screening Program provides for early identification and follow-up of hearing impaired infants and infants at risk for developing a hearing impairment.

In FFY 2006, a total of $8,018,167 in federal funds are budgeted to support programs and services for children and adolescents. Funds will be awarded to local health departments to support a broad range of activities to improve the health of children and adolescents. Activities include home visiting, care coordination, child fatality review, school health, health screenings, immunizations, and health education/outreach. Funds will also be used to administer the Childhood Lead Screening Program to include promotion of increased blood lead testing in 20 of the state's 24 jurisdictions, and outreach and education to increase lead awareness. Grantees include local health departments, universities, and the Maryland Coalition to End Childhood Lead Poisoning. Finally, CMCH will use these funds to support programs and activities concerned with school and adolescent health, asthma education and outreach, childhood nutrition and obesity issues, and SIDS counseling, outreach and education.

The FFY 2006 budget includes $5,554,945 in federal funds only to support programs and services for CSHCN. These activities and programs will be administered by the Office for Genetics and Children with Special Health Care Needs. Direct care services to be funded include payment of specialty care for uninsured and underinsured CSHCN as well as two medical day care centers for medically fragile infants and young children. Funding will go to local health departments, Parent's Place of Maryland, and University Centers of Excellence for enabling services such as information and referral, care coordination/wrap-around services, and a variety of respite activities. Population-based services funded will include the newborn screening follow-up accomplished through the Office. Specialty medical centers and some local health departments will also receive funding to support specialty clinic infrastructure, with particular emphasis on neurodevelopmental, genetic, and hematologic services.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting Documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.